

ADH
MARK DOGOLI
04-0807

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend Item #20b, 23e, 24a-b per fhme G829 3/24/04 tas
Unpend Item #23a-b per fhme G829 3/23/04 tas
AMEND ITEM #22 PER FH G828 2/09/04 Certificate of Death

Reg. No.

2004 03501

Physician
/Medical
Examiner

Funeral
Director

1. Decedent's Name (First, Middle, Last)

Mark G. Dogoli

2. Date of Death

Month Day Year
JANUARY 30, 2004

3. Time of Death

0622 A M

4a. Facility Name (If not institution, give street and number)

6282 TUFTED MOSS

4b. City, Town, or Location of Death

COLUMBIA

4c. County of Death

HOWARD

5. Social Security Number

08760-0117

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

33 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Month Day Year
March 29, 1970

9. Birthplace (State or Foreign Country)

New York

Usual Residence of Decedent

10a. State

Maryland

10b. County

Howard

10c. City, Town or Location

Columbia

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

6282 Tufted Moss

10f. Zip Code

21046

10g. Citizen of What Country?

United States

11. Marital Status

1 ☒ Never Married 2 ☐ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,
Black, White, etc.

Specify: White

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

5+

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Medical Doctor

16b. Kind of Business/Industry

Hospital

17. Father's Name (First, Middle, Last)

Joseph Dogoli

18. Mother's Name (First, Middle, Maiden Sumame)

Sally Gundry

19a. Informant's Name/Relationship (Type, Print)

Stephanie Kroepfl, Sister

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

414 Monaco Parkway, Denver, Colorado 80220

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of
cemetery, crematory or other place)

Venice Memorial Gdns. 2/9/04

Date

20c. Location - City or Town, State

Venice, Florida

21. Signature of Funeral Service Licensee

Theresa M. King

22. Name and Address of Facility

Ewing Funeral Home - FARLEY's FUN. H.M.
140 East Venice Ave., Venice Florida 34285

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.

Approximate
Interval Between
Onset and Death

Immediate Cause (Final
disease or condition
resulting in death)

a. Cardiac Arrhythmia

Due to (or as a consequence of):

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

b. Cardiac Disease

Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

IF FEMALE:

23b. Was decedent pregnant
in the past 12 months?
1 ☐ Yes 2 ☐ No
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy
4 ☐ Pregnant at time of death 5 ☐ Other (specify)
9 ☐ Unknown

23d. Date of Delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

25. Was case referred to medical
examiner?
1 ☒ Yes 2 ☐ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☒ Other (Specify) AT SCENE

27. Manner of Death

1 ☒ Natural 5 ☐ Pending
investigation
2 ☐ Accident 6 ☐ Could not be
determined
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury
(Month, Day Year)

28b. Time of
Injury

28c. Injury at
Work?

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number,
City or Town, State)

29a. Certifier
(Check only
one)

1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
and manner stated.

29b. Signature and title of certifier

Theresa M. King

29c. License number

OCME

29d. Date signed (Month, Day, Year)

JANUARY 30, 2004

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Theresa M. King

111 Penn Street, Baltimore, Maryland 21201

31. Date filed (Month, Day, Year)

FEB 09 2004

32. Registrar's Signature

John A. Smith

State
Registrar

ORIGINAL

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show
any injury or other traumatic event, the Medical Examiner must be notified at
once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial transit

To Be Completed by Funeral Director

Medical Certification; To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene
 1- Amend Item 23a per Dr. G828, 02/09/04
 Certificate of Death
 Reg. No. 2004 03502

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) PATRICIA DEXTER		2. Date of Death Month January Day 31 Year 2004		3. Time of Death 19:15 M
	4a. Facility Name (If not institution, give street and number) Johns Hopkins Hospital Baltimore		4b. City, Town, or Location of Death Baltimore		4c. County of Death N/A
Funeral Director	5. Social Security Number 212-22-9453	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 77 Yrs.	8. Date of Birth (Month, Day, Year) Sept. 20, 1926	9. Birthplace (State or Foreign Country) Maryland
	Usual Residence of Decedent				
To Be Completed by Funeral Director	10a. State Maryland	10b. County Baltimore	10c. City, Town or Location Baltimore		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
	10e. Street and Number 11 Devon Hill Rd.		10f. Zip Code 21210		10g. Citizen of What Country? U.S.A.
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) +5		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Mechanical Engineer		16b. Kind of Business/Industry Company Owner
	17. Father's Name (First, Middle, Last) Harry John Stockum		18. Mother's Name (First, Middle, Maiden Surname) Elizabeth Rieger		
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) Susan Cesare (Daughter)		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 609 Edgevale Road Baltimore, Maryland 21210		
	20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Greenmount Crematory		20c. Location - City or Town, State Baltimore, Maryland
	21. Signature of Funeral Service Licensee Robert M. Kratz		22. Name and Address of Facility Mitchell-Wiedefeld F.H. Inc. 6500 York Rd. Baltimore, Maryland 21212		
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. ASPIRATION Pneumonia Due to (or as a consequence of): b. CHRONIC OBSTRUCTIVE PULMONARY DISEASE Due to (or as a consequence of): c. Due to (or as a consequence of): d. Approximate Interval Between Onset and Death 18 hours years				
	23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Unknown		23d. Date of delivery Month Day Year
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. CRITICAL AORTIC STENOSIS ISCHEMIC CARDIOMYOPATHY					
To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M
	28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred		
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)		
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				
29b. Signature and title of certifier DR. SIGRID BERG, MD MEDICAL DIRECTOR		29c. License number RES-000		29d. Date signed (Month, Day, Year) JANUARY 31, 2004	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SIGRID BERG, MD JOHNS HOPKINS HOSPITAL, 600 NORTH WOLFE STREET, BALTIMORE, MD 21287					
31. Date filed (Month, Day, Year) FEB 09 2004		32. Registrar's Signature [Signature]			

Baltimore, Maryland 21215-0036
 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
 Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,
 To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
 To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2004 03503

Certificate of Death

Reg. No.

1- For State Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <u>Pennis Evans</u>				2. Date of Death Month <u>February</u> Day <u>5</u> Year <u>2004</u>		3. Time of Death <u>1 25A</u> M	
	4a. Facility Name (If not institution, give street and number) <u>UMMS</u>				4b. City, Town, or Location of Death <u>Baltimore</u>		4c. County of Death <u>n/a</u>	
Funeral Director	5. Social Security Number <u>220 723485</u>	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <u>46</u> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <u>05/06/57</u>		9. Birthplace (State or Foreign Country) <u>Maryland</u>
	Usual Residence of Decedent							
10a. State <u>MD</u>		10b. County <u>Prince Georges</u>		10c. City, Town or Location <u>Laurel</u>			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
10e. Street and Number <u>15411 Arbory Way</u>				10f. Zip Code <u>20707</u>		10g. Citizen of What Country? <u>U.S.A.</u>		
11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <u>White</u>		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <u>2</u> College (1-4or 5+) <u>College</u>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <u>Maintenance</u>		16b. Kind of Business/Industry <u>BWI Airport</u>		
17. Father's Name (First, Middle, Last) <u>Daniel E. Evans, Sr.</u>				18. Mother's Name (First, Middle, Maiden Surname) <u>Dorothy Stansbury</u>				
19a. Informant's Name/Relationship (Type, Print) <u>Darrell Evans, Brother</u>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>15411 Arbory Way, Laurel, Maryland 20707</u>				
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) <u>Balt-Wash Crematory</u>		Date <u>02/08/2004</u>		20c. Location - City or Town, State <u>Laurel, Maryland</u>
21. Signature of Funeral Service Licensee <u>Kenya Stewart</u>				22. Name and Address of Facility <u>Fleck Funeral Home, Inc.</u> <u>7601 Sandy Spring Road, Laurel, Maryland 20707</u>				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) <u>Anoxic Brain Injury</u> Due to (or as a consequence of): <u>Pneumonia</u> Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <u>one month</u>								Approximate Interval Between Onset and Death <u>two days</u>
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown				23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Unknown <input type="checkbox"/> Other (specify)		23d. Date of delivery Month Day Year		
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)				
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined				28a. Date of Injury (Month, Day Year)		28b. Time of Injury <u>M</u>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
28d. Describe how injury occurred				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				
28f. Location (Street and Number or Rural Route Number, City or Town, State)								
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. Signature and title of certifier <u>Sarah Murthi MD</u>				
29c. License number <u>MO31827</u>				29d. Date signed (Month, Day, Year) <u>2/8/04</u>				
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <u>Sarah Murthi, MD 22 South Greene Street Baltimore, MD 21201</u>								
31. Date filed (Month, Day, Year) <u>FEB 09 2004</u>				32. Registrar's Signature <u>[Signature]</u>				

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar Unpend Item #23a, 27, 28a-f per me 6826 2/10/04 Certificate of Death

Reg. No.

2004 03504

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Kevin L. Fuller		2. Date of Death Month January Day 23 , Year 2004		3. Time of Death 1250 A M	
	4a. Facility Name (If not institution, give street and number) 3815 Park Heights Avenue		4b. City, Town, or Location of Death Baltimore		4c. County of Death N/A	
Funeral Director	5. Social Security Number unk.	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 19 Yrs.	If Under 1 Year Months	If Under 24 Hrs. Hours Min.	8. Date of Birth Month Oct. Day 5 , Year 1984
	9. Birthplace (State or Foreign Country) Maryland					
Usual Residence of Decedent						
10a. State MD		10b. County Baltimore		10c. City, Town or Location Woodlawn		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
10e. Street and Number 2454 Golders Green Ct.			10f. Zip Code 21244		10g. Citizen of What Country? USA	
11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: Black
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 10th College (1-4or 5+)			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Assistant Driver		16b. Kind of Business/Industry Fabrication	
17. Father's Name (First, Middle, Last) Jake Arco			18. Mother's Name (First, Middle, Maiden Surname) Florine Fuller			
19a. Informant's Name/Relationship (Type, Print) Ruth White - Grandmother			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2454 Golders Green Ct. Woodlawn, MD 21244			
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Metro Crematory		20c. Location - City or Town, State 2-6-04 Catonsville, MD		
21. Signature of Funeral Service Licensee 		22. Name and Address of Facility GARY P. MARCH FH 270 FRED HILTON PASS BALTO MD 21229				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Smoke inhalation Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last						
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <input checked="" type="checkbox"/> Unknown		23d. Date of delivery Month Day Year		
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						
23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown						
24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No				
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) At Scene				
27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year) 1/22/04		28b. Time of Found 10:42 P M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) House		28d. Describe how injury occurred Victim of house fire				
28f. Location (Street and Number or Rural Route Number, City or Town, State) 3815 Park Heights Ave. Baltimore, MD						
29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.						
29b. Signature and title of certifier 		29c. License number O.C.M.E.		29d. Date signed (Month, Day, Year) January 23, 2004		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) J. L. Loeck MD 111 Penn Street, Baltimore, Maryland 21201						
31. Date filed (Month, Day, Year) FEB 09 2004		32. Registrar's Signature 				

e2004 03505

1- For State Amend Item 20c per FH, G828, 02/09/04 dht
Registrar

Reg. No.

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Amend Item 5 per FH, G833, 07/01/04dhb

Certificate of Death

Reg. No.

2004 03506

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Tracie Dawn Gambrill				2. Date of Death Month: 02 Day: 03 Year: 2004		3. Time of Death 9:15AM M	
	4a. Facility Name (If not institution, give street and number) Gilchrist Center				4b. City, Town, or Location of Death Towson		4c. County of Death Baltimore	
Funeral Director	5. Social Security Number 217-92-8554	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 37 Yrs.	If Under 1 Year Months: Days: Hours: Min.	8. Date of Birth (Month, Day, Year) 02/09/1966	9. Birthplace (State or Foreign Country) Maryland		
	Usual Residence of Decedent							
To Be Completed by Funeral Director	10a. State MD	10b. County Baltimore	10c. City, Town or Location White Marsh			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
	10e. Street and Number 10403 Vincent Farm Lane - Rear				10f. Zip Code 21162		10g. Citizen of What Country? U.S.A.	
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12): 12 College (1-4 or 5+): 2		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Housewife		16b. Kind of Business/Industry Homemaking			
	17. Father's Name (First, Middle, Last) Gene Vance Lease				18. Mother's Name (First, Middle, Maiden Surname) Margaret Ann Sams			
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) Charles A. Gambrill (husband)				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10403 Vincent Farm Lane - Rear - White Marsh, MD 21162			
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Holly Hill Mem. Gdns.		20c. Date 02/05/2004		20d. Location - City or Town, State Baltimore, Maryland	
	21. Signature of Funeral Service Licensee E. F. Lassahn				22. Name and Address of Facility E. F. Lassahn Funeral Home, P.A. 11750 Belair Road - Kingsville, MD 21087			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Breast Cancer							
	23b. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
State Registrar	23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <input type="checkbox"/> Unknown				23d. Date of delivery Month: Day: Year:			
	24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No			
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) Hospice			
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No	
	28d. Describe how injury occurred				28e. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
29b. Signature and title of certifier W.A. Riley, MD				29c. License number 025205		29d. Date signed (Month, Day, Year) February 3, 2004		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) W.A. Riley GBMC 6701 N. Charles St. Balto. MD 21204								
31. Date filed (Month, Day, Year) FEB 09 2004				32. Registrar's Signature [Signature]				

Gambrill, Tracie 2-3-04 9:15 AM

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2004 03507

1- For
State
Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Frank Galloway				2. Date of Death Month Day Year Feb. 7, 2004				3. Time of Death 9:30 A M	
	4a. Facility Name (If not institution, give street and number) Upper Chesapeake Medical Center				4b. City, Town, or Location of Death Bel Air				4c. County of Death Harford	
Funeral Director	5. Social Security Number 217-30-7475		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 79 Yrs.		8. Date of Birth (Month, Day, Year) July 30, 1924		9. Birthplace (State or Foreign Country) Maryland	
	Usual Residence of Decedent									
10a. State Maryland		10b. County Harford		10c. City, Town or Location Bel Air				10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
10e. Street and Number 719 S. Fountain Green Road				10f. Zip Code 21015		10g. Citizen of What Country? United States				
11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: White		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 2nd College (1-4 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Grounds Keeper				16b. Kind of Business/Industry Community LawnService		
17. Father's Name (First, Middle, Last) Unknown				18. Mother's Name (First, Middle, Maiden Surname) Unknown						
19a. Informant's Name/Relationship (Type, Print) Beatrice Dean				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 719 S. Fountain Green Road Bel Air, Maryland 21015						
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) West Arundel Crematory				20c. Location - City or Town, State 2/9/2004 Odenton, Maryland		
21. Signature of Funeral Service Licensee <i>Quanta R. Thomas</i>				22. Name and Address of Facility Anatomy Gift Registry 7526 Connelley Drive, Suite E Hanover, MD 21076						
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Coronary Artery Disease										
Approximate Interval Between Onset and Death 10 years										
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last a. Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d.										
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown										
23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <input type="checkbox"/> Unknown										
23d. Date of delivery Month Day Year										
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Hypertension										
23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown										
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No										
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No										
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide				28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
				28d. Describe how injury occurred				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		
				28f. Location (Street and Number or Rural Route Number, City or Town, State)						
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.										
29b. Signature and title of certifier <i>[Signature]</i>				29c. License number D35012				29d. Date signed (Month, Day, Year) February 8, 2004		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) J. Kevin Lynch MD 2 North Ave. Bel Air, Md. 21014										
31. Date filed (Month, Day, Year) FEB 09 2004				32. Registrar's Signature <i>[Signature]</i>						

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

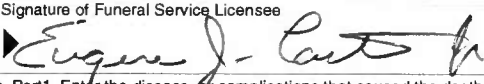


State of Maryland / Department of Health and Mental Hygiene										2004 03508			
1- For State Registrar Amend Item #5 per FHG828 2/12/04 EW Certificate of Death										Reg. No.			
Physician /Medical Examiner		1. Decedent's Name (First, Middle, Last) <u>Rosalee C. Gollar</u>						2. Date of Death Month <u>February</u> Day <u>6</u> Year <u>2004</u>		3. Time of Death <u>19:40 PM</u>			
		4a. Facility Name (If not institution, give street and number) <u>University of Maryland Medical Center</u>				4b. City, Town, or Location of Death <u>Baltimore</u>		4c. County of Death <u>n/a</u>					
Funeral Director		5. Social Security Number <u>216-28-1771</u> <u>216-28-1711</u>		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <u>71</u> Yrs.		8. Date of Birth (Month, Day, Year) <u>July 21 1932</u>		9. Birthplace (State or Foreign Country) <u>Maryland</u>			
		Usual Residence of Decedent											
		10a. State <u>Md.</u>		10b. County <u>n/a</u>		10c. City, Town or Location <u>Baltimore</u>				10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No			
		10e. Street and Number <u>600 Light Street</u>				10f. Zip Code <u>21230</u>		10g. Citizen of What Country? <u>U.S.A.</u>					
		11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <u>white</u>					
		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <u>8</u> College (1-4 or 5+) <u>0</u>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <u>Salesperson</u>				16b. Kind of Business/Industry <u>Retail</u>					
		17. Father's Name (First, Middle, Last) <u>Alfred Gawronski</u>				18. Mother's Name (First, Middle, Maiden Surname) <u>Mary Matilda Brown</u>							
		19a. Informant's Name/Relationship (Type, Print) <u>Patricia Spano (Daughter)</u>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>8063 Catherine Ave. Pasadena, Md. 21122</u>							
		20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <u>Holy Cross Cemetery</u>		Date <u>02/10/04</u>		20c. Location - City or Town, State <u>Baltimore, Md.</u>					
		21. Signature of Funeral Service Licensee <u>John S. Gorman</u>				22. Name and Address of Facility <u>McCully-Polyniak Funeral Home P.A.</u> <u>130 E. Fort Ave. Baltimore, Md. 21230</u>							
Physician /Medical Examiner		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. <u>Sepsis</u> Due to (or as a consequence of): b. _____ Due to (or as a consequence of): c. _____ Due to (or as a consequence of): d. _____ Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last										Approximate Interval Between Onset and Death <u>~ 3 months</u>	
		IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 9 <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) _____ 9 <input type="checkbox"/> Unknown				23d. Date of delivery Month _____ Day _____ Year _____					
		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown					
								24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			
		25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)									
		27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <u>M</u>		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred			
						28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)			
		29a. Certifier (Check only one) 1 <input type="checkbox"/> Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.											
		29b. Signature and title of certifier <u>Chauncey T. Jones, MD</u>				29c. License number <u>P17664</u>		29d. Date signed (Month, Day, Year) <u>February 6, 2004</u>					
		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <u>Chauncey T. Jones, MD 22 S. Greene St., Baltimore, MD 21201</u>											
State Registrar		31. Date filed (Month, Day, Year) <u>FEB 09 2004</u>		32. Registrar's Signature <u>B. Sparks</u>									

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2004 03509

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) MADELINE M. GRUPP						2. Date of Death Month Day Year FEB. 3, 2004		3. Time of Death 12:55 AM	
	4a. Facility Name (If not institution, give street and number) ALICE BYRD TAWES HOSPICE						4b. City, Town, or Location of Death CRISFIELD		4c. County of Death SOMERSET	
Funeral Director	5. Social Security Number 218-01-9400		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 83 Yrs.		8. Date of Birth (Month, Day, Year) 1/26/21		9. Birthplace (State or Foreign Country) MARYLAND	
	Usual Residence of Decedent									
To Be Completed by Funeral Director	10a. State MD		10b. County SOMERSET		10c. City, Town or Location WESTOVER				10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	10e. Street and Number 6700 ELMO DRYDEN ROAD				10f. Zip Code 21871		10g. Citizen of What Country? USA			
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: WHITE		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) UNKNOWN College (1-4 or 5+) UNKNOWN				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) LABORER			16b. Kind of Business/Industry COLUMBIA SPECIALTY		
	17. Father's Name (First, Middle, Last) CHARLES ENGLER						18. Mother's Name (First, Middle, Maiden Surname) UNKNOWN			
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) WILLIAM GRUPP / SON						19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6700 ELMO DRYDEN RD. WESTOVER, MD. 21871			
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) OAK LAWN CEMETERY			Date 2/6/04		20c. Location - City or Town, State BALTIMORE, MD.		
	21. Signature of Funeral Service Licensee 						22. Name and Address of Facility KACZOROWSKI FUNERAL HOME P.A. 1201 DUNDALK AVE. BALTIMORE, MD. 21222			
	23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Acute Intracerebral Hemorrhage Due to (or as a consequence of): b. _____ Due to (or as a consequence of): c. _____ Due to (or as a consequence of): d. _____ Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last									
	Approximate Interval Between Onset and Death 16 days									
To Be Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Essential Hypertension						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown			
							24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred	
			28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)			
State Registrar	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.									
	29b. Signature and title of certifier 				29c. License number D29505		29d. Date signed (Month, Day, Year) 02-03-2004			
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) GREGORIO M. BELLOSO, M.D., 5302 CHINABERRY DR., SALISBURY, MD 21801									
31. Date filed (Month, Day, Year) FEB 09 2004		32. Registrar's Signature 								

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1. For State Registrar Amend Item 7 per FH, G828, 02/09/04 ddb Certificate of Death

Reg. No.

2004 03510

Physician
/Medical
ExaminerFuneral
Director

1. Decedent's Name (First, Middle, Last)

FANNIE

GINSBURG

2. Date of Death

Month
FEBDay
03Year
2004

3. Time of Death

12:45A M

4a. Facility Name (If not institution, give street and number)

HOSPICE OF BALTIMORE - GILCHRIST CENTER

TOWSON

4c. County of Death

BALTIMORE

5. Social Security Number

215-40-1581

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

94 93

8. Date of Birth

AUG 23, 1909

9. Birthplace (State or Foreign Country)

MARYLAND

Usual Residence of Decedent

10a. State

MD

10b. County

N/A

10c. City, Town or Location

BALTIMORE

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

1190 W. NORTHERN PARKWAY, #503

10f. Zip Code

21210

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)
10

College (1-4or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

HOMEMAKER

16b. Kind of Business/Industry

OWN HOME

17. Father's Name (First, Middle, Last)

WILLIAM

PODOLSKY

18. Mother's Name (First, Middle, Maiden Surname)

ROSE

STEINSCHLEIFER

19a. Informant's Name/Relationship (Type, Print)

BILL GINSBURG (SON)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2 SUDBROOK CT. BALTIMORE, MD 21208

20a. Method of Disposition

1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

OHEB SHALOM MEM. PARK

Date

2/5/04

20c. Location - City or Town, State

REISTERSTOWN, MD

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

SOL LEVINSON & BROS., INC.

8900 REISTERSTOWN RD. PIKESVILLE, MD 21208

23. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Left parietal stroke

Approximate Interval Between Onset and Death

weeks

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☒ No
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy
4 ☐ Pregnant at time of death 5 ☐ Other (specify)
9 ☐ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Dementia

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ OOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☒ Other (Specify) Hospice

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

W. A. Riley, M.D.

29c. License number

025205

29d. Date signed (Month, Day, Year)

February 3, 2004

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

W. A. Riley, G. BMC 6701 N. Charles St. Balto. MD 21208

31. Date filed (Month, Day, Year)

FEB 03 2004

32. Registrar's Signature

Blanca H. Smith

State
Registrar

Eunice Mary Hann
04-01047
MAN

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2004 03511

1- For State Registrar

Physician / Medical Examiner

1. Decedent's Name (First, Middle, Last)

EUNICE MARY HANN

2. Date of Death

February 06, 2004

3. Time of Death

1953 P M

4a. Facility Name (If not institution, give street and number)

11507 Harford Road

4b. City, Town, or Location of Death

Glen Arm

4c. County of Death

Baltimore

5. Social Security Number

226-24-2539

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

82 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth (Month, Day, Year)

JANUARY 9, 1922

9. Birthplace (State or Foreign Country)

PENNSYLVANIA

Usual Residence of Decedent

10a. State

MARYLAND

10b. County

BALTIMORE

10c. City, Town or Location

GLEN ARM

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

11507 HARFORD ROAD

10f. Zip Code

21057

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4or 5+)

12

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

HAIRDRESSER

16b. Kind of Business/Industry

COSMETOLOGY

17. Father's Name (First, Middle, Last)

ROSS GARLAND

18. Mother's Name (First, Middle, Maiden Surname)

ZELLAH BELLE MELLOTT

19a. Informant's Name/Relationship (Type, Print)

CARL D. HANN / HUSBAND

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

11507 HARFORD ROAD, GLEN ARM, MD 21057

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

EVANS FUNERAL CHAPEL - BEL AIR

Date

FEB. 10, 2004

20c. Location - City or Town, State

FOREST HILL, MD

21. Signature of Funeral Service Licensee

Kimberly A. Zutterlin

22. Name and Address of Facility

EVANS FUNERAL CHAPEL
8800 HARFORD ROAD, PARKVILLE, MD 21234

23a. Part I. Enter the disease, or complications that caused the death, shock, or heart failure. List only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest.

Immediate Cause (Final disease or condition resulting in death)

a. Multiple Trauma

Due to (or as a consequence of):

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Approximate Interval Between Onset and Death

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☒ No
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy
4 ☐ Pregnant at time of death 5 ☐ Other (specify)
9 ☐ Unknown

23d. Date of delivery
Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?
1 ☒ Yes 2 ☐ No

24b. Were autopsy findings available prior to completion of cause of death?
1 ☒ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☒ Yes 2 ☐ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☒ Other (Specify) At scene

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

2-6-04

28b. Time of Injury

7:23 P M

28c. Injury at Work?

1 ☐ Yes 2 ☒ No

28d. Describe how injury occurred

Observed (S) Person in car impact with fixed

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

DRIVEWAY AND YARD

28f. Location (Street and Number or Rural Route Number, City or Town, State)

11507 HARFORD ROAD, BALTIMORE CO., MD

29a. Certifier (Check only one)

1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Margaret A. Koros

29c. License number

O.C.M.E.

29d. Date signed (Month, Day, Year)

February 07, 2004

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MARGARET A. KOROS

111 Penn Street, Baltimore, Maryland 21201

31. Date filed (Month, Day, Year)

FFB 09 2004

32. Registrar's Signature

Anna B. Sparks

State Registrar

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at 9050.

Physician / Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2004 03512

1- For
State
Registrar

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at 202-398-0028.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Physician
/Medical
ExaminerFuneral
Director

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

1. Decedent's Name (First, Middle, Last) Lee Hildebrandt		2. Date of Death Month Day Year February 5 2004		3. Time of Death 5:00 A^M	
4a. Facility Name (If not institution, give street and number) 20339 Gore Mill Road		4b. City, Town, or Location of Death Freeland		4c. County of Death Baltimore	
5. Social Security Number 215 30 2399	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 69 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) April 10 1934
9. Birthplace (State or Foreign Country) Baltimore City, MD					
Usual Residence of Decedent					
10a. State Maryland	10b. County Baltimore	10c. City, Town or Location Freeland		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
10e. Street and Number 20339 Gore Mill Road		10f. Zip Code 21053		10g. Citizen of What Country? USA	
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: Korean		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:	
14. Race - American Indian, Black, White, etc. Specify: White					
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4or 5+) 2		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Installer		16b. Kind of Business/Industry Telephone Co.	
17. Father's Name (First, Middle, Last) Leonard A Hildebrandt		18. Mother's Name (First, Middle, Maiden Surname) Gladys J Cherry			
19a. Informant's Name/Relationship (Type, Print) Donna Labadie-Waldt		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20339 Gore Mill Road Freeland, Md. 21053			
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Metro Crematory Inc		20c. Location - City or Town, State Baltimore, Maryland	
20d. Date February 6 2004					
21. Signature of Funeral Service Licensee Matthew Gosselin Chopinski		22. Name and Address of Facility Lassahn Funeral Home Inc. 7401 Belair Road Baltimore, Maryland 21236			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Metastatic Bladder Cancer		a. Due to (or as a consequence of):		Approximate Interval Between Onset and Death 4 years	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		b. Due to (or as a consequence of):			
		c. Due to (or as a consequence of):			
		d. Due to (or as a consequence of):			
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <input type="checkbox"/> Unknown		23d. Date of delivery Month Day Year	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		23e. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown			
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M	
		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred	
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)	
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier Nancy A. Dawson M.D.			
		29c. License number MD D31586		29d. Date signed (Month, Day, Year) February 6, 2004	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) NANCY A. DAWSON MD		Univ. of Maryland 22 S. Greene St Baltimore MD 21201			
31. Date filed (Month, Day, Year) FEB 09 2004		32. Registrar's Signature [Signature]			

State
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2004 03513

1- For
State
RegistrarPhysician
/Medical
ExaminerFuneral
Director

1. Decedent's Name (First, Middle, Last)

Eugene

S

Hubbe

2. Date of Death

February 5, 2004

3. Time of Death

5:00 AM

4a. Facility Name (If not institution, give street and number)

6502 Cleveland Avenue

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

N/A

5. Social Security Number

220-20-6011

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

72 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
May 30, 1931

9. Birthplace (State or Foreign Country)

MD.

Usual Residence of Decedent

10a. State

MD.

10b. County

N/A

10c. City, Town or Location

Baltimore City

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

6502 Cleveland Avenue

10f. Zip Code

21222

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

11 Years

College (1-4 or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working life. DO NOT use retired)

Longshoreman

16b. Kind of Business/Industry

Steamship Trade

17. Father's Name (First, Middle, Last)

Philip Hubbe

18. Mother's Name (First, Middle, Maiden Surname)

Anna Janowicz

19a. Informant's Name/Relationship (Type, Print)

IDA HUBBE / wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

6502 CLEVELAND AVE. BALTO. MD. 21222

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

SACRED HEART OF JESUS FEB 9 2004

Date

20c. Location - City or Town, State

BALTO. MD.

21. Signature of Funeral Service Licensee

Anthony C. Connelly

22. Name and Address of Facility

CONNELLY FUNERAL HOME OF BUNDALKPA
7110 SOLLERS POINT RD. 21222

23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Hypopharyngeal Squamous Cell Carcinoma
Due to (or as a consequence of):

Approximate Interval Between Onset and Death

1 yr

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
5 ☐ Other (specify)
9 ☐ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an autopsy performed?
1 ☐ Yes 2 ☒ No24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No25. Was case referred to medical examiner?
1 ☐ Yes 2 ☒ NoHospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation
2 ☐ Accident 6 ☐ Could not be determined
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Matthew Kashima

29c. License number

D0057258

29d. Date signed (Month, Day, Year)

2/5/04

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MATTHEW KASHIMA 4940 Eastern Ave BALTIMORE MD 21224

31. Date filed (Month, Day, Year)

FEB 09 2004

32. Registrar's Signature

[Signature]

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23e or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2004 03514

Certificate of Death

Reg. No.

1- For
State
RegistrarPhysician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

ELIZABETH HILLFENDING

2. Date of Death
Month Day Year

FEBRUARY 4 2004

3. Time of Death

2:56 AM

Funeral
Director

4a. Facility Name (If not institution, give street and number)

Mercy Medical Center

4b. City, Town, or Location of Death

BALTIMORE

4c. County of Death

BALTIMORE

5. Social Security Number

216-34-3124

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

66

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

November 19, 1937

9. Birthplace (State or Foreign Country)

MD.

Usual Residence of Decedent

10a. State

MD.

10b. County

N/A

10c. City, Town or Location

Baltimore

10d. Inside City Limits

☒ Yes 2 ☐ No

10e. Street and Number

1133 South Bonsal Street

10f. Zip Code

21224

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: White

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12 years

College (1-4or 5+)

2 years

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Handicapp Leader

16b. Kind of Business/Industry

Baltimore County

17. Father's Name (First, Middle, Last)

Sebastiano Sudano

18. Mother's Name (First, Middle, Maiden Surname)

Gicamina Impallaria

19a. Informant's Name/Relationship (Type, Print)

Michael Hillferding husband

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1133 South Bonsal Street, Baltimore, Md. 21224

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Sacred Heart Of Jesus Cem.

Date
February
7, 2004

20c. Location - City or Town, State

Dundalk, Md.

21. Signature of Funeral Service Licensee

Anthony Connelly

22. Name and Address of Facility

Connelly Funeral Home Of Dundalk, P.A.
7110 Sollers Point Road, Dundalk, Md. 2122223a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

a. SMALL BOWEL INFARCTION

Due to (or as a consequence of):

b. SMALL BOWEL OBSTRUCTION

Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate
Interval Between
Onset and Death

< 1 week

UNKNOWN

IF FEMALE:

23b. Was decedent pregnant
in the past 12 months?1 ☐ Yes 2 ☒ No
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown3 ☐ Ectopic pregnancy5 ☐ Other (specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an
autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings available
prior to completion of cause of
death?1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending
investigation
2 ☐ Accident 6 ☐ Could not be
determined
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury

(Month, Day Year)

28b. Time of
Injury

M

28c. Injury at
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
and manner stated.

29b. Signature and title of certifier

Julia T. Bonkum

29c. License number

D5036

29d. Date signed (Month, Day, Year)

FEBRUARY 4, 2004

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

JULIA T BONKUM 301 ST PAUL PL BALTIMORE MD 21201

31. Date filed (Month, Day, Year)

FEB 09 2004

32. Registrar's Signature

Benjamin B. Sparks

State
Registrar

Baltimore, Maryland 21215-0036

permt. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28e-f show
any injury or other traumatic event, the Medical Examiner must be notified at
once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2004 03515

Certificate of Death

Reg. No.

1- For
State
RegistrarPhysician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Rosalie Hall

2. Date of Death

February 4th 2004 22:59p M

3. Time of Death

4a. Facility Name (If not institution, give street and number)

Howard County General Hosp.

4b. City, Town, or Location of Death

Columbia

4c. County of Death

Howard

Funeral
Director

5. Social Security Number

212-32-0776

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

92 Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

(Month, Day, Year)
June 17, 1911

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

MD

10b. County

Howard

10c. City, Town or Location

Clarksville

10d. Inside City Limits

1 ☐ Yes 2 ☒ No
XX

10e. Street and Number

12201 Hall Shop Road

10f. Zip Code

21029

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☒ Never Married 2 ☐ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: White

15. Decedent's Education
(Specify only highest grade completed)Elementary/Secondary (0-12)
Grade 8

College (1-4or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Clerk

16b. Kind of Business/Industry

Howard County Gov.

17. Father's Name (First, Middle, Last)

Herbert Elmer Hall

18. Mother's Name (First, Middle, Maiden Surname)

Rosalie Earp

19a. Informant's Name/Relationship (Type, Print)

Dorothy Stull / sister

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

12210 Hall Shop Road Clarksville, Md. 21029

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Mt. Zion Church Cem.

Date

Feb 11, 04

20c. Location - City or Town, State

Highland, Maryland

21. Signature of Funeral Service Licensee

G. S. K. / M00770

22. Name and Address of Facility

Donaldson Funeral Home, P.A.
313 Talbott Avenue Laurel, Maryland 2070723a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

a. Acute myocardial infarction

b. Severe anemia

c. upper gastrointestinal tract bleeding

d. pneumonia

Approximate
Interval Between
Onset and DeathSequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

IF FEMALE:

23b. Was decedent pregnant
in the past 12 months?1 ☐ Yes 2 ☒ No
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy
4 ☐ Pregnant at time of death 5 ☐ Other (specify)
9 ☐ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

atrial fibrillation, cardiomyopathy
hypertension

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an
autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings available
prior to completion of cause of
death?1 ☐ Yes 2 ☒ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation
6 ☐ Could not be determined28a. Date of Injury
(Month, Day, Year)28b. Time of
Injury

M

28c. Injury at
Work?1 ☐ Yes 2 ☐ No28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)2 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
and manner stated.

29b. Signature and title of certifier

S. O. M.

29c. License number

D50870

29d. Date signed (Month, Day, Year)

February 4th 2004

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Susan Abdo, MD 5005 Signal Bell Ln. Clarksville MD 21029

State
Registrar

31. Date filed (Month, Day, Year)

FEB 09 2004

32. Registrar's Signature

D. A. A.

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show
any injury or other traumatic event, the Medical Examiner must be notified at
once.Physician
/Medical
ExaminerTo the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit
permit.

To Be Completed by Funeral Director

Medical Certification; To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2004 03516

1- For
State
RegistrarPhysician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Carla Marie Hardesty

2. Date of Death

Month Day Year
February 8, 2004

3. Time of Death

12:24 a M

Funeral
Director

4a. Facility Name (If not institution, give street and number)

1039 Harrison Drive

4b. City, Town, or Location of Death

Laurel

4c. County of Death

Prince George's

5. Social Security Number

213-54-7907

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

55 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
March 4, 1948

9. Birthplace (State or Foreign Country)

Washington, DC

Usual Residence of Decedent

10a. State

MD

10b. County

Prince George's

10c. City, Town or Location

Laurel

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

1039 Harrison Drive

10f. Zip Code

20707

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No.

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.
Specify: White15. Decedent's Education
(Specify only highest grade completed)Elementary/Secondary (0-12)
Grade 9

College (1-4 or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired)

Sales

16b. Kind of Business/Industry

Retail

17. Father's Name (First, Middle, Last)

Alfred Dorn

18. Mother's Name (First, Middle, Maiden Surname)

Edna Mae Dodd

19a. Informant's Name/Relationship (Type, Print)

Ronald E. Hardesty, Sr./Husband

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1039 Harrison Drive Laurel, Maryland 20707

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

West Arundel Crem.

Date

Feb 13, 2004

20c. Location - City or Town, State

Odenton, MD

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Donaldson Funeral Home, P.A.

/ M00770

313 Talbott Avenue Laurel, Maryland 20707

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Metastatic Colon Cancer

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death
15 Months

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☒ No
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy
4 ☐ Pregnant at time of death 5 ☐ Other (specify)
9 ☐ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy performed?
1 ☐ Yes 2 ☒ No24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☒ No25. Was case referred to medical examiner?
1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number

D 18219

29d. Date signed (Month, Day, Year)

February 9, 2004

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Stephen Staal, MD 1221 Mercantile Lane Largo, Maryland 20744

31. Date filed (Month, Day, Year)

32. Registrar's Signature

FEB 09 2004

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
ExaminerTo the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial/transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

12

State
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

1- For State Registrar

2004 03517

Patient known as Monette Henderson

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permitted. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

1. Decedent's Name (First, Middle, Last) <i>Monette Henderson</i>		2. Date of Death Month <i>February</i> Day <i>3</i> Year <i>2004</i>		3. Time of Death <i>18:15 PM</i>	
4a. Facility Name (If not institution, give street and number) <i>Sinai Hospital of Baltimore</i>		4b. City, Town, or Location of Death <i>Baltimore</i>		4c. County of Death <i>N/A</i>	
5. Social Security Number <i>156-36-2156</i>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <i>57</i> Yrs.	
8. Date of Birth (Month, Day, Year) <i>July 26, 1946</i>		9. Birthplace (State or Foreign Country) <i>Massachusetts</i>			
Usual Residence of Decedent					
10a. State <i>Maryland</i>		10b. County <i>N/A</i>		10c. City, Town or Location <i>Baltimore</i>	
10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		10e. Street and Number <i>1701 Eutaw Place Apt. 307</i>		10f. Zip Code <i>21217</i>	
10g. Citizen of What Country? <i>USA</i>		11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:	
13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <i>Black</i>		15. Decedent's Education (Specify only highest grade completed) <i>12th Grade</i>	
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <i>unemployed</i>		16b. Kind of Business/Industry <i>N/A</i>		17. Father's Name (First, Middle, Last) <i>unknown</i>	
18. Mother's Name (First, Middle, Maiden Surname) <i>Norice Moore</i>		19a. Informant's Name/Relationship (Type, Print) <i>Benjamin Henderson - son</i>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>2725 Fire Rd. Atlantic City, New Jersey 08234</i>	
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <i>Mt. Zion Cemetery</i>		20c. Location - City or Town, State <i>Landstowne Maryland</i>	
21. Signature of Funeral Service Licensee <i>Kevin Parker</i>		22. Name and Address of Facility <i>Parker Charles E. Crematory F.S.P.A. 3512 Frederick Ave. Baltimore, Maryland 21229</i>			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.					
Immediate Cause (Final disease or condition resulting in death) a. <i>Ischemic Bowel</i> Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of):					
Approximate Interval Between Onset and Death <i>1 month</i>					
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown					
23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input checked="" type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify)					
23d. Date of delivery Month Day Year					
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Hypertension</i>					
23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown					
24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No					
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined					
28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)	
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.					
29b. Signature and title of certifier <i>Kevin Parker MD</i>		29c. License number <i>RES - 000</i>		29d. Date signed (Month, Day, Year) <i>February 6, 2004</i>	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <i>Kenneth Malik Jackson, MD SINAI HOSPITAL OF BALTIMORE</i>					
31. Date filed (Month, Day, Year) <i>FEB 09 2004</i>		32. Registrar's Signature <i>Kevin Parker</i>			

State Registrar

1- For
State
Registrar

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) LINDA ERIN HOLZMAN			2. Date of Death Month Day Year FEBRUARY 4, 2004		3. Time of Death 1:20 P M	
	4a. Facility Name (If not institution, give street and number) 21 FOXMOOR COURT			4b. City, Town, or Location of Death OWINGS MILLS		4c. County of Death BALTIMORE	
Funeral Director	5. Social Security Number 217-50-3394		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 54 Yrs.		8. Date of Birth (Month, Day, Year) dec. 26, 1949
	9. Birthplace (State or Foreign Country) md						
To Be Completed by Funeral Director	Usual Residence of Decedent						
	10a. State MD		10b. County BALTIMORE		10c. City, Town or Location OWINGS MILLS		10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
	10e. Street and Number 21 FOXMOOR COURT			10f. Zip Code 21117		10g. Citizen of What Country? U.S.A.	
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: WHITE
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 4 College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) SOCIAL WORKER		16b. Kind of Business/Industry STATE OF MARYLAND		
	17. Father's Name (First, Middle, Last) WILLIAM HOLZMAN			18. Mother's Name (First, Middle, Maiden Surname) FLORENCE OXMAN			
	19a. Informant's Name/Relationship (Type, Print) MARC HOLZMAN / BROTHER			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2606 WASHINGTON AVENUE - CHEVY CHASE 20815			
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) BALTIMORE HEBREW CEM.		Date 2/6/2004		20c. Location - City or Town, State REISTERSTOWN, MD
	21. Signature of Funeral Service Licensee <i>Michael Kruger</i>			22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Uterine SARcoma						
23b. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last a. Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of):							
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input checked="" type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 4 <input type="checkbox"/> Pregnant at time of death 9 <input type="checkbox"/> Unknown		3 <input type="checkbox"/> Ectopic pregnancy 5 <input type="checkbox"/> Other (specify)		23d. Date of delivery Month Day Year	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown	
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No					
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28d. Describe how injury occurred					
28f. Location (Street and Number or Rural Route Number, City or Town, State)							
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. Signature and title of certifier <i>Paul Celano, MD</i>		29c. License number D30929		29d. Date signed (Month, Day, Year) 2/5/2004			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Paul Celano MD 6569 N. Charles ST, BALT, MD 21204							
31. Date filed (Month, Day, Year) FEB 09 2004		32. Registrar Signature <i>James H. Smith</i>					

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2004 03519

Physician
/Medical
ExaminerFuneral
Director

1. Decedent's Name (First, Middle, Last)

Rose Marie Harris

2. Date of Death

February 5, 2004

3. Time of Death

3:45 AM

4a. Facility Name (If not institution, give street and number)

Stella Maris

4b. City, Town, or Location of Death

Timonium

4c. County of Death

Baltimore

5. Social Security Number

212-12-0155

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

86

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

11/14/1917

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

MD

10b. County

Baltimore

10c. City, Town or Location

Overlea

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

4300 Cardwell Avenue Apt. 222

10f. Zip Code

21236

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)
12

College (1-4 or 5+)

16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Clerk

16b. Kind of Business/Industry

Social Security Admin.

17. Fether's Name (First, Middle, Last)

Dominick Loangelo

18. Mother's Name (First, Middle, Maiden Surname)

Josephine Mistretta

19a. Informant's Name/Relationship (Type, Print)

Jesse Harris/Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

25 Beverly Drive Hillsborough, New Jersey 08844

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Parkwood

Date

2/9/04

20c. Location - City or Town, State

Baltimore, Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Miller-Dippel Funeral Home Inc.

6415 Belair Road Baltimore, Maryland 21206

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. CHRONIC OBSTRUCTED PULMONARY DISEASE

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

26. Place of Death (Check only one)

4 ☐ Nursing Home5 ☐ Residence6 ☒ Other (Specify) HOSPICE

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation
2 ☐ Accident 6 ☐ Could not be determined
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury et Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D43725

29d. Date signed (Month, Day, Year)

2/5/04

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DR. TARIQ MAHMOOD 2300 DULANEY VALLEY RD. TIMONIUM, MD 21093

31. Date filed (Month, Day, Year)

FEB 09 2004

32. Registrar's Signature

[Signature]

State
Registrar

FEBRUARY 5, 2004 4:05 a.m.

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

ROSE HARRIS

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

15

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

1- For State Registrar

2004 03520

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) MARY C. IHNAT				2. Date of Death Month FEB Day 5 Year 2004		3. Time of Death 20:44 M	
	4a. Facility Name (If not institution, give street and number) HERITAGE NURSING CENTER				4b. City, Town, or Location of Death DUNDALK		4c. County of Death BALTIMORE	
Funeral Director	5. Social Security Number 205-03-6085		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 83 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) JAN 10, 1921	9. Birthplace (State or Foreign Country) PA
	Usual Residence of Decedent							
To Be Completed by Funeral Director	10a. State MD.	10b. County BALTIMORE	10c. City, Town or Location DUNDALK			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
	10e. Street and Number 1519 RITA RD.				10f. Zip Code 21222		10g. Citizen of What Country? USA	
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: WHITE	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 8yrs College (1-4or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) CUSTODIAN		16b. Kind of Business/Industry Postal Service			
To Be Completed by Physician/Medical Examiner	17. Father's Name (First, Middle, Last) GEORGE MILLER				18. Mother's Name (First, Middle, Maiden Surname) MARTHA MESKO			
	19a. Informant's Name/Relationship (Type, Print) MARTHA KOEHLER DAUGHTER				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1519 RITA RD. DUNDALK			
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) HOLY ROSARY		Date FEB 9 2004		20c. Location - City or Town, State DUNDALK	
	21. Signature of Funeral Service Licensee <i>[Signature]</i>		22. Name and Address of Facility CONNELLY FUNERAL HOME OF DUNDALK 7110 SOLTERS POINT RD. 21222					
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. PNEUMONIA LEFT MID AND LOWER LUNG Due to (or as a consequence of): b. DIABETES MELLITUS Due to (or as a consequence of): c. HYPERTENSION Due to (or as a consequence of): d. DEMENTIA							
	23b. If FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown							
	23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Other (specify) <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Unknown							
	23d. Date of delivery Month Day Year							
To Be Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. DEPRESSION							
	23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown							
	24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No							
To Be Completed by Physician/Medical Examiner	26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)				27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined			
	28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred	
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)			
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.							
State Registrar	29b. Signature and title of certifier Savinder K Toor M.D.				29c. License number D27182		29d. Date signed (Month, Day, Year) 2/6/04	
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Savinder K Toor 2 Market Pike Dundalk MD 21222							
31. Date filed (Month, Day, Year) FEB 09 2004								
32. Registrar's Signature <i>[Signature]</i>								

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2004 03521

1- For State Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Henry Iacovone			2. Date of Death Month Day Year FEBRUARY 3, 2004		3. Time of Death 11:17A^M	
	4a. Facility Name (If not institution, give street and number) Saint Joseph Medical Center			4b. City, Town, or Location of Death Towson		4c. County of Death Baltimore	
Funeral Director	5. Social Security Number 118-09-5873		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 84 Yrs.		8. Date of Birth (Month, Day, Year) July 22 1919
	9. Birthplace (State or Foreign Country) NY		10a. State MD		10b. County Balto		10c. City, Town or Location Timonium
To Be Completed by Funeral Director	10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		10e. Street and Number 2020 Dumont Rd		10f. Zip Code 20193		10g. Citizen of What Country? USA
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: 1941-1945		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 9 College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Carpenter		16b. Kind of Business/Industry Housing		
	17. Father's Name (First, Middle, Last) Caesar Iacovone			18. Mother's Name (First, Middle, Maiden Surname) Carmenle Lombardi			
	19a. Informant's Name/Relationship (Type, Print) Elizabeth Legenhausen			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2020 Dumont Rd Timonium, MD 20193			
	20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Metro Crematory		20c. Location - City or Town, State Balto, MD		Date 2-11-04
	21. Signature of Funeral Service Licensee Benet Thach		22. Name and Address of Facility IIAM 1230 Mid-Valley Dr. Jessup, PA 18434				
	23a. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. ISCHEMIC CARDIOMYORATHY						
	23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown						
	23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <input type="checkbox"/> Unknown						
23d. Date of delivery Month Day Year							
To Be Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. RENAL FAILURE HEMOSIDEROSIS						23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown
	24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No						24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)				
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
	28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)		
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.						29b. Signature and title of certifier [Signature]
	29c. License number D 37254		29d. Date signed (Month, Day, Year) 2/3/04				
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ROON P. LIM M.D. 7601 OSLER DRIVE TOWSON MARYLAND 21204						
	31. Date filed (Month, Day, Year) FEB 09 2004		32. Registrar's Signature [Signature]				

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2004 03522

1- For
State
RegistrarPhysician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

WILLIE MAE JOHNSON

2. Date of Death

FEBRUARY 05 2004

3. Time of Death

12:05 PM

Funeral
Director

4a. Facility Name (If not institution, give street and number)

WOOD SAMARITAN HOSPITAL

4b. City, Town, or Location of Death

BALTIMORE

4c. County of Death

NA

5. Social Security Number

422-32-3164

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

93 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

October 25, 1910

9. Birthplace (State or Foreign Country)

ALABAMA

Usual Residence of Decedent

10a. State

MD

10b. County

NA

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

1713 Poplar Grove

10f. Zip Code

21216

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Domestic

16b. Kind of Business/Industry

Homes

17. Father's Name (First, Middle, Last)

Willie Lee

18. Mother's Name (First, Middle, Maiden Surname)

Fannie Lee

19a. Informant's Name/Relationship (Type, Print)

Kelly P. Parker / Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1713 Poplar Grove Baltimore, MD 21216

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Woodlawn Cemetery

Date

2-12-04

20c. Location - City or Town, State

Baltimore, MD

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Wylie Funeral Home 638N. Gilmore St. Balto, MD 21217

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. PNEUMONIA

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. SEPSIS

Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☒ No9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death4 ☐ Pregnant at time of death9 ☐ Unknown3 ☐ Ectopic pregnancy5 ☐ Other (Specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24e. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

28. Place of Death (Check only one)

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

2 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Manisha Bahl, MD

29c. License number

D 0058913

29d. Date signed (Month, Day, Year)

FEBRUARY 05 2004

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MANISHA BAHL, MD 5601 LOCHRAVEN BOULEVARD, BALTIMORE, MARYLAND 21239

31. Date filed (Month, Day, Year)

FEB 09 2004

32. Registrar's Signature

[Signature]

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
ExaminerTo the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2004 03523

1- For
State
RegistrarPhysician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Thomas I. Jordan

2. Date of Death

February 6 2004

3. Time of Death

1:15 PM

4a. Facility Name (If not institution, give street and number)

ST. Agnes Hospital

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

NIA

Funeral
Director

5. Social Security Number

815-80-4630

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

37 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Aug. 11, 1966

9. Birthplace (State or Foreign Country)

New York

Usual Residence of Decedent

10a. State

MD

10b. County

NIA

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

3904 Ridgewood Ave.

10f. Zip Code

21215

10g. Citizen of What Country?

USA

11. Marital Status

1 ☒ Never Married 2 ☐ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

11th

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Case Manager

16b. Kind of Business/Industry

Youth Service

17. Father's Name (First, Middle, Last)

Thomas Jordan

18. Mother's Name (First, Middle, Maiden Surname)

Eartha Lee Simmons

19a. Informant's Name/Relationship (Type, Print)

Lulamay Jordan-grandmother

19b. Mailing Address (Street and Number, or Rural Route Number, City or Town, State, Zip Code)

5334 Cordelia Ave. Balto., MD 21215

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Metro Crematory

Date

2-14-04

20c. Location - City or Town, State

Catonsville, MD

21. Signature of Funeral Service Licensee



22. Name and Address of Facility

Gary P. March FH 870 Fredhillton Pass Balto., MD 21239

Physician
/Medical
Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Myocardial Ischemia

Approximate Interval Between Onset and Death

Ten days

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☒ No
3 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death
3 ☐ Ectopic pregnancy
4 ☐ Pregnant at time of death
5 ☐ Other (specify)
9 ☐ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Human Immunodeficiency Virus
Acquired Immune Deficiency Syndrome
Central Nervous System Lymphoma

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an autopsy performed?
1 ☐ Yes 2 ☒ No24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☒ No25. Was case referred to medical examiner?
1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation
6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☒ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier



29c. License number

P16699

29d. Date signed (Month, Day, Year)

February, 07, 2004

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Deepak Baskaran 900 cotton Ave Baltimore, MD 21229

31. Date filed (Month, Day, Year)

FEB - 9 2004

32. Registrar's Signature

State
Registrar

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2004 03524

1- For
State
RegistrarPhysician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

VELMA JACOBS

2. Date of Death

February 4 2004

3. Time of Death

15:50 M

4a. Facility Name (If not institution, give street and number)

Johns Hopkins Bayview Medical Center

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

N/A

Funeral
Director

5. Social Security Number

215-24-8224

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

79

Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

(Month, Day, Year)
Sept. 19, 1924

9. Birthplace (State or Foreign Country)

Kentucky

Usual Residence of Decedent

10a. State

Maryland

10b. County

Baltimore

10c. City, Town or Location

Dundalk

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

2908 Plainfield Road

10f. Zip Code

21222

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No.
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: White

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

1 Year

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Chief Registrar

16b. Kind of Business/Industry

Johns Hopkins Hospital

17. Father's Name (First, Middle, Last)

John Holt

18. Mother's Name (First, Middle, Maiden Surname)

Goldie Ball

19a. Informant's Name/Relationship (Type, Print)

Cheryl Atkins / Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2010 East Pratt Street Baltimore, Maryland 21231

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Garrison Forest V.A.Cem. 2/10/2004 Owings Mills, MD

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Duda-Ruck Funeral Home of Dundalk, Inc.

7922 Wise Ave. Dundalk, Maryland 21222

23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)a. Pneumonia
Due to (or as a consequence of):Approximate
Interval Between
Onset and Death

days

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Lastb. Congestive heart failure, exacerbation.
Due to (or as a consequence of):

Week

c. Chronic Ischemic heart disease.
Due to (or as a consequence of):

Years

IF FEMALE:

23b. Was decedent pregnant
in the past 12 months?
1 ☐ Yes 2 ☒ No
9 ☐ Unknown23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown3 ☐ Ectopic pregnancy
5 ☐ Other (specify)23d. Date of delivery
Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown25. Was case referred to medical
examiner?
1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation
2 ☐ Accident 6 ☐ Could not be determined
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury

(Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number

RES-000

29d. Date signed (Month, Day, Year)

Feb. 4, 2004

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

REZA YAHMAMI, 4940 Eastern Ave, Baltimore, MD 21224

31. Date filed (Month, Day, Year)

FEB 09 2004

32. Registrar's Signature

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

6

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2004 03525

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Carolyn Jackson

2. Date of Death

Jan. 30, 2004

3. Time of Death

1:00 p.m.

4a. Facility Name (If not institution, give street and number)

419 St. George's Ave. Apt. 8

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

N/A

Funeral
Director

5. Social Security Number

218-46-6817

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

53 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Dec. 4, 1950

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

N/A

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

419 St. George's Ave. Apt. 8

10f. Zip Code

21218

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)
12th Grade

College (1-4or 5+)

16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

unemployed

16b. Kind of Business/Industry

N/A

17. Father's Name (First, Middle, Last)

George Sturgis

18. Mother's Name (First, Middle, Maiden Surname)

Mary Dyer

19a. Informant's Name/Relationship (Type, Print)

Joyce Wanson - sister

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1217 C Crimson Tree Way Edgewood, Maryland 21040

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Metro Crematory

Date

2/9/04

20c. Location - City or Town, State

Catonsville, Maryland

21. Signature of Funeral Service Licensee

Kevin Parker

22. Name and Address of Facility

Kevin A. Parker Funeral Home, P.A.
3512 Frederick Ave. Baltimore, Maryland 21229

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

e. Chronic Renal Failure

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

{

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Congestive Heart Failure

Diabetes

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☒ Yes 2 ☐ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Melvin Melinsky MD

29c. License number

D-27921

29d. Date signed (Month, Day, Year)

2/6/04

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Melvin Melinsky - 2809 Boston St Balt. 21229

31. Date filed (Month, Day, Year)

FEB 09 2004

32. Registrar's Signature

[Signature]

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

State
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar **AMEND ITEM #10g PER FJ g828 2/09/04** **Certificate of Death**

Reg. No.

2004 03526

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Dorothy Jones		2. Date of Death Month Jan. Day 28 Year 2004		3. Time of Death 6:00p M
	4a. Facility Name (If not institution, give street and number) Gilchrist Center		4b. City, Town, or Location of Death Towson		4c. County of Death Baltimore
Funeral Director	5. Social Security Number 229-03-3974	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 95 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.
	8. Date of Birth Month Aug. Day 25 Year 1908		9. Birthplace (State or Foreign Country) Virginia		
To Be Completed by Funeral Director	Usual Residence of Decedent		10a. State Maryland		
	10b. County N/A		10c. City, Town or Location Baltimore		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
	10e. Street and Number 1039 Ashburton St.		10f. Zip Code 21216		10g. Citizen of What Country? USA
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:
	14. Race - American Indian, Black, White, etc. Specify: Black		15. Decedent's Education (Specify only highest grade completed) 12th Grade		
	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker		16b. Kind of Business/Industry N/A		
	17. Father's Name (First, Middle, Last) James Campbell		18. Mother's Name (First, Middle, Maiden Surname) Eleanor Ball		
	19a. Informant's Name/Relationship (Type, Print) Theresa Waddy - niece		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6868 Parsons Ave. Baltimore, Maryland 21207		
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Arbutus Mem. Park		20c. Location - City or Town, State 2/3/04 Arbutus Maryland
	21. Signature of Funeral Service Licensee Kevin Parker		22. Name and Address of Facility Forker, Chavis & Chromette F.S. PA 3512 Frederick Ave. Baltimore, Maryland 21229		
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Congestive heart failure Due to (or as a consequence of): Hypertension Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):					
23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown					
23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Other (specify) <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Unknown					
23d. Date of delivery Month Day Year					
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.					
23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown					
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) Hospice					
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined					
28a. Date of Injury (Month, Day Year)					
28b. Time of Injury M					
28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
28d. Describe how injury occurred					
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)					
28f. Location (Street and Number or Rural Route Number, City or Town, State)					
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.					
29b. Signature and title of certifier W.A. Riley, MD					
29c. License number 025205					
29d. Date signed (Month, Day, Year) January 29, 2004					
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) W.A. Riley GMC 6701 N-Charles St. Balto. md 21208					
31. Date filed (Month, Day, Year) FEB 09 2004					
32. Registrar's Signature [Signature]					

Wednesday, January 28th, 2004 @ 1800
Baltimore, Maryland 21215-0036

Jones, Dorothy 1/28/04 C6P
Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State Registrar

DHMH 17 Rev 1/2001

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2004 03527

1- For
State
RegistrarPhysician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Pauline A. Jankowiak

2. Date of Death

February 7, 2004

3. Time of Death

3:57 PM

4a. Facility Name (If not institution, give street and number)

Johns Hopkins Bayview Medical Center

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

—

Funeral
Director

5. Social Security Number

217-07-3676

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

90 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
March 14, 1913

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

MD

10b. County

N/A

10c. City, Town or Location

Baltimore City

10d. Inside City Limits

☒ Yes 2 ☐ No

10e. Street and Number

420 Imla Street

10f. Zip Code

21224

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☒ Never Married 2 ☐ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: White

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4or 5+)

5

College (1-4or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working life. DO NOT use retired)

Machine Operator

16b. Kind of Business/Industry

Tailoring

17. Father's Name (First, Middle, Last)

Stanley Jankowiak

18. Mother's Name (First, Middle, Maiden Surname)

Frances Yanka

19a. Informant's Name/Relationship (Type, Print)

Matilda J. Sobus (Sister)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

420 Imla Street Baltimore, Maryland 21224

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

St. Stanislaus Cemetery

Date

2/10/04

20c. Location - City or Town, State

Baltimore, Maryland

21. Signature of Funeral Service Licensee

Michael Jankowiak

22. Name and Address of Facility

Charles S. Zeiler & Son, Inc.

6224 Eastern Avenue Baltimore, MD 21224

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest.

Immediate Cause (Final disease or condition resulting in death)

a. Adult Respiratory Distress Syndrome

Due to (or as a consequence of):

b. Pneumococcal Pneumonia

Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

7 days

14 days

IF FEMALE:

23b. Was decedent pregnant

in the past 12 months?

1 ☐ Yes 2 ☒ No9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death4 ☐ Pregnant at time of death9 ☐ Unknown3 ☐ Ectopic pregnancy5 ☐ Other (specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Congestive Heart Failure, Atrial Fibrillation,
Sick Sinus Syndrome

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ OOA

26. Place of Death (Check only one)

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation2 ☐ Accident 6 ☐ Could not be determined3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury

(Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier

(Check only one)

2 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

L. Christine Tuttle, MD, PhD

29c. License number

33717

29d. Date signed (Month, Day, Year)

February 7, 2004

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

L. Christine Tuttle, Johns Hopkins Bayview Medical Center, 4940 Eastern Avenue, Baltimore, MD 21224

31. Date filed (Month, Day, Year)

FEB 09 2004

32. Registrar's Signature

[Signature]

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permitted. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28e-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

8

State
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Register AMEND ITEM #19a PER INF G828 2/10/03 Certificate of Death

Reg. No. 2004 03528

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Betty Jones		2. Date of Death Month January Day 31 Year 2004		3. Time of Death 7:05 PM
	4a. Facility Name (If not institution, give street and number) Fairhaven		4b. City, Town, or Location of Death Sykesville		4c. County of Death Carroll
Funeral Director	5. Social Security Number 214-40-3196	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 93 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.
	8. Date of Birth (Month, Day, Year) April 6, 1910		9. Birthplace (State or Foreign Country) Maryland		
To Be Completed by Funeral Director	Usual Residence of Decedent				
	10a. State MD	10b. County Carroll	10c. City, Town or Location Sykesville		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
	10e. Street and Number 7200 Third Avenue C43		10f. Zip Code 21784		10g. Citizen of What Country? U.S.A.
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:
	14. Race - American Indian, Black, White, etc. Specify: White				
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 2 College (1-4or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Secretary		16b. Kind of Business/Industry Education
	17. Father's Name (First, Middle, Last) Nesbitt Cox		18. Mother's Name (First, Middle, Maiden Sumame) Bessie Renner		
	19a. Informant's Name/Relationship (Type, Print) Beverly Searone BEVERLY SCAVONE		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20220 Middletown Road Freeland, Maryland 21053		
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Dulaney Valley		20c. Location - City or Town, State 2/7/04 Baltimore, Maryland
	21. Signature of Funeral Service Licensee Jessica Hogg		22. Name and Address of Facility Miller-Dippel Funeral Home 6415 Belair Road Baltimore, Maryland 21206		
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sepsis				Approximate Interval Between Onset and Death 5 days
	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last				
	a. Due to (or as a consequence of):				
	b. Due to (or as a consequence of):				
	c. Due to (or as a consequence of):				
	d. Due to (or as a consequence of):				
	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown				23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <input type="checkbox"/> Unknown
	23d. Date of delivery Month Day Year				
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				
	23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown				
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M	
		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred	
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)	
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.					
29b. Signature and title of certifier John C. Abel		29c. License number 00059943		29d. Date signed (Month, Day, Year) February 2, 2004	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) John C. Abel, M.D. 295 Stoner Ave. Suite 307 westminster, MD 21157					
31. Date filed (Month, Day, Year) FEB 09 2004		32. Registrar's Signature John C. Abel			

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For Amend Item 23a per Dr. G828,02/09/04dbb Certificate of Death

Reg. No. 2004 03529

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) JESSIE L JETER		2. Date of Death Month JANUARY Day 19 Year 2004		3. Time of Death 3:07 AM
	4a. Facility Name (If not institution, give street and number) HARBOR HOSPITAL CENTER		4b. City, Town, or Location of Death BALTIMORE		4c. County of Death BALTIMORE
Funeral Director	5. Social Security Number 101-26-9921	6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 69 Yrs.	8. Date of Birth (Month, Day, Year) May 6, 1934	9. Birthplace (State or Foreign Country) New York
	Usual Residence of Decedent				
To Be Completed by Funeral Director	10a. State MD	10b. County Anne Arundel	10c. City, Town or Location Linthicum		10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
	10e. Street and Number 561 Forest View Road		10f. Zip Code 21090		10g. Citizen of What Country? United States
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:	13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4or 5+) 4		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Registered Nurse		16b. Kind of Business/Industry Health Care
To Be Completed by Physician/Medical Examiner	17. Father's Name (First, Middle, Last) Maynard Lilley		18. Mother's Name (First, Middle, Maiden Surname) Unknown		
	19a. Informant's Name/Relationship (Type, Print) Robin Jeter Son		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 561 Forest View Road, Linthicum, MD 21090		
	20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Bayview Crematory, Inc. 1-24-2004 Baltimore, MD		20c. Location - City or Town, State
	21. Signature of Funeral Service Licensee <i>[Signature]</i>		22. Name and Address of Facility Ambrose Funeral Home of Lansdowne 2719 Hammonds Ferry Rd., Lansdowne, MD 21227		
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Aspiration. Aspiration Pneumonia				Approximate Interval Between Onset and Death 2 hours
	Immediate Cause (Final disease or condition resulting in death) STROKE				3 days
	Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last				
	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 9 <input type="checkbox"/> Unknown				23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) 9 <input type="checkbox"/> Unknown
23d. Date of delivery Month Day Year					
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.					
23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown					
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	28d. Describe how injury occurred
28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.					
29b. Signature and title of certifier <i>[Signature]</i> Medical Doctor		29c. License number P-17785		29d. Date signed (Month, Day, Year) 1/19/04	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) HARIS ALI 3001 S. HANOVER ST, BALTIMORE, MD-21225					
31. Date filed (Month, Day, Year) FEB 09 2004		32. Registrar's Signature <i>[Signature]</i>			

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2004 03530

1- For
State
Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Doris Mae Jones		2. Date of Death Month Day Year Feb 6 2004		3. Time of Death 3:30am
	4a. Facility Name (If not institution, give street and number) Upper Cheasapeake Medical Center		4b. City, Town, or Location of Death Belair		4c. County of Death Harford
Funeral Director	5. Social Security Number 227-50-2833	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 64 Yrs.	8. Date of Birth (Month, Day, Year) July 13 1939	9. Birthplace (State or Foreign Country) Virginia
	Usual Residence of Decedent				
To Be Completed by Funeral Director	10a. State Md	10b. County Harford	10c. City, Town or Location Abingdon		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
	10e. Street and Number 421 DeerHill Circle		10f. Zip Code 21009		10g. Citizen of What Country? U.S.A.
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:
	14. Race - American Indian, Black, White, etc. Specify: Black		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12th College (1-4or 5+)		
To Be Completed by Physician/Medical Examiner	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Food Service Director		16b. Kind of Business/Industry Country Club		
	17. Father's Name (First, Middle, Last) Aubrey Rose Sr.		18. Mother's Name (First, Middle, Maiden Surname) Gracie Henderson		
	19a. Informant's Name/Relationship (Type, Print) Regina Johnson/daughter		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 421 DeerHill Circle Abingdon, MD 21009		
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) KingMemorialPark		20c. Location - City or Town, State Feb 12, 2004 Balto. Md,
Physician /Medical Examiner	21. Signature of Funeral Service Licensee 		22. Name and Address of Facility CALVIN B. SCRUGGS FUNERAL HOME 1412 E. PRESTON ST. BALTO., MD 21213		
	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. SEPSIS				
	23b. Part 2. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. ASPIRATION PNEUMONIA				
	23c. Part 3. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. ILLEUS				
To Be Completed by Physician/Medical Examiner	23d. Date of delivery Month Day Year		23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		
	23f. Date of death Month Day Year		23g. Date of death Month Day Year		
	23h. Date of death Month Day Year		23i. Date of death Month Day Year		
	23j. Date of death Month Day Year		23k. Date of death Month Day Year		
To Be Completed by Physician/Medical Examiner	24. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. DISPHAGIA MULTIPLE CEREBRAL VASCULAR ACCIDENTS				
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				
	26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Patient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)				
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined				
To Be Completed by Physician/Medical Examiner	28a. Date of Injury (Month, Day Year)				
	28b. Time of Injury M				
	28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				
	28d. Describe how injury occurred				
To Be Completed by Physician/Medical Examiner	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				
	28f. Location (Street and Number or Rural Route Number, City or Town, State)				
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				
	29b. Signature and title of certifier 				
To Be Completed by Physician/Medical Examiner	29c. License number H55922				
	29d. Date signed (Month, Day, Year) FEBRUARY 6, 2004				
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ANTHONY W. SAMPHILUPO DO, 500 UPPER CHEASAPEAKE DR, BEL AIR, MD 21014				
	31. Date filed (Month, Day, Year) FEB 09 2004				
State Registrar	32. Registrar's Signature 				

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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2004 03531

1- For State Registrar

Physician /Medical Examiner

Funeral Director

1. Decedent's Name (First, Middle, Last) Robin Ann Kroll		2. Date of Death Month: February Day: 05 Year: 2004		3. Time of Death 1434 P M	
4a. Facility Name (If not institution, give street and number) 7421 Bay Front Road		4b. City, Town, or Location of Death Edgemere		4c. County of Death Baltimore	
5. Social Security Number 218-78-5220	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 41 Yrs.	If Under 1 Year Months: Days: Hours: Min.	8. Date of Birth (Month, Day, Year) 11-2-62	9. Birthplace (State or Foreign Country) Maryland
Usual Residence of Decedent		10c. City, Town or Location Edgemere		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
10a. State MD	10b. County BALTIMORE	10e. Street and Number 7421 Bay Front Rd		10f. Zip Code 21219	10g. Citizen of What Country? USA
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:	
14. Race - American Indian, Black, White, etc. Specify: white		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) homemaker	
16b. Kind of Business/Industry at home		17. Father's Name (First, Middle, Last) Gordon Enos		18. Mother's Name (First, Middle, Maiden Surname) Jean Ramsburg	
19a. Informant's Name/Relationship (Type, Print) Dawn Carter		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7847 Woodbine Rd, Airville PA 17302			
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) EVANS FUNERAL CHAPEL - BELAIR, PA		20c. Location - City or Town, State FOREST HILL, MD	
21. Signature of Funeral Service Licensee Kimberly G. Spontony		22. Name and Address of Facility 3 NEWPORT DR., FOREST HILL, EVANS FUNERAL CHAPEL - BELAIR, PA, MD 21050			
23a. Part I. Enter the disease or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Smoke and soot inhalation Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of):		23b. If female, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <input checked="" type="checkbox"/> Unknown		23d. Date of delivery Month: Day: Year:	
23c. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown			
24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No			
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) At scene			
27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year) February 5, 2004		28b. Time of Injury 2:10 PM	
28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred house fire		28e. Location (Street and Number or Rural Route Number, City or Town, State) 7421 Bayfront Rd Edgemere MD	
29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier Tasha Z Greenberg MD		29c. License number O.C.M.E.	
29d. Date signed (Month, Day, Year) February 06, 2004		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Tasha Z Greenberg MD 111 Penn Street, Baltimore, Maryland 21201			
31. Date filed (Month, Day, Year) FEB 09 2004		32. Registrar's Signature Anna B Sparks			

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

State Registrar

Nancy Susan Kreamer
04-0894
AKG

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2004 03532

1- For State Registrar AMEND ITEM #4c PER ME G828 2/09/04 Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Nancy Susan Kreamer			2. Date of Death Month Day Year February 2, 2004			3. Time of Death 8:32 A ^M						
	4a. Facility Name (If not institution, give street and number) 554 Jeffrey Road			4b. City, Town, or Location of Death Millersville			4c. County of Death Allegany ANNE ARUNDEL						
Funeral Director	5. Social Security Number 217-74-1742		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 44 Yrs.		8. Date of Birth (Month, Day, Year) June 2, 1959		9. Birthplace (State or Foreign Country) Maryland				
	Usual Residence of Decedent 10a. State Maryland			10b. County Anne Arundel			10c. City, Town or Location Millersville			10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			
10e. Street and Number 554 Jeffrey Road										10f. Zip Code 21108		10g. Citizen of What Country? United States	
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:			13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White				
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 11th College (1-4or 5+) 11th			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Deli Clerk			16b. Kind of Business/Industry Grocery Store							
17. Father's Name (First, Middle, Last) Morris Edward Thomas					18. Mother's Name (First, Middle, Maiden Surname) Betty McGinnis								
19a. Informant's Name/Relationship (Type, Print) David Wayne Kreamer					19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7959 Telegraph Road Lot#153 Severn, Maryland 21144								
20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) West Arundel Crematory			Date 02/09/2004		20c. Location - City or Town, State Odenton, Maryland					
21. Signature of Funeral Service Licensee [Signature] M00957			22. Name and Address of Facility Donaldson Funeral Home & Crematory, P.A. 1411 Annapolis Road Odenton, Maryland 21113										
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Asphyxia Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of):										Approximate Interval Between Onset and Death		
	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input checked="" type="checkbox"/> Unknown			23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 4 <input type="checkbox"/> Pregnant at time of death 9 <input checked="" type="checkbox"/> Unknown			3 <input type="checkbox"/> Ectopic pregnancy 5 <input type="checkbox"/> Other (specify)			23d. Date of delivery Month Day Year			
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.										23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown			
25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No			26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other (Specify) At scene										
27. Manner of Death 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input checked="" type="checkbox"/> Homicide			28a. Date of Injury (Month, Day Year) February 2, 2004		28b. Time of Injury 8:31 A ^M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		28d. Describe how injury occurred subject was strangled				
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) home			28f. Location (Street and Number or Rural Route Number, City or Town, State) 554 Jeffrey Rd, Millersville, MD										
29a. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.													
29b. Signature and title of certifier [Signature] Tasha Z Greenberg MD			29c. License number O.C.M.E.			29d. Date signed (Month, Day, Year) February 3, 2004							
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Tasha Z Greenberg M.D. 111 Penn Street, Baltimore, Maryland 21201													
31. Date filed (Month, Day, Year) FEB 09 2004			32. Registrar's Signature [Signature]										

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

1- For State Registrar

Certificate of Death

Reg. No.

Physician / Medical Examiner	1. Decedent's Name (First, Middle, Last) Richard Evan Kroll				2. Date of Death Month Day Year February 05, 2004				3. Time of Death 1441 P M						
	4a. Facility Name (If not institution, give street and number) 7421 Bay Front Road				4b. City, Town, or Location of Death Edgemere				4c. County of Death Baltimore						
Funeral Director	5. Social Security Number 215-68-4797		6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		7. Age (In yrs. last birthday) 47 Yrs.		8. Date of Birth (Month, Day, Year) 9/14/1956		9. Birthplace (State or Foreign Country) Maryland						
	Usual Residence of Decedent														
10a. State Maryland		10b. County Baltimore		10c. City, Town or Location Edgemere				10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No							
10e. Street and Number 7421 Bay Front Road				10f. Zip Code 21219				10g. Citizen of What Country? U. S. A.							
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White							
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4or 5+) 12				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Laborer				16b. Kind of Business/Industry Bethlehem Steel							
17. Father's Name (First, Middle, Last) Henry John Kroll				18. Mother's Name (First, Middle, Maiden Surname) Catherine Lorraine Maccubbin											
19a. Informant's Name/Relationship (Type, Print) Sharyn Lee Trent (Sister)				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1122 Stephen Drive Middle River, Maryland 21220											
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) Oak Lawn Cemetery		Date 2/10 2004		20c. Location - City or Town, State Baltimore, Maryland								
21. Signature of Funeral Service Licensee Michael C. Saffian Sr.				22. Name and Address of Facility Bruzdinski Funeral Home PA 1407 Old Eastern Avenue Essex, Maryland 21221											
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Smoke and soot inhalation Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last										Approximate Interval Between Onset and Death					
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown			23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 4 <input type="checkbox"/> Pregnant at time of death 9 <input type="checkbox"/> Unknown 3 <input type="checkbox"/> Ectopic pregnancy 5 <input type="checkbox"/> Other (specify)				23d. Date of delivery Month Day Year								
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.										23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown					
24a. Was an autopsy performed? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No										24b. Were autopsy findings available prior to completion of cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No					
25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No			26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other (Specify) On scene												
27. Manner of Death 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input checked="" type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide			28a. Date of Injury (Month, Day, Year) February 5, 2004		28b. Time of Injury 2:10 PM		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		28d. Describe how injury occurred house fire						
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) home			28f. Location (Street and Number or Rural Route Number, City or Town, State) 7421 Bayfront Rd, Edgemere MD												
29a. Certifier (Check only one) 1. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.										29b. Signature and title of certifier Tasha Z Greenberg MD		29c. License number O.C.M.E.		29d. Date signed (Month, Day, Year) February 06, 2004	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Tasha Z Greenberg M.D. 111 Penn Street, Baltimore, Maryland 21201															
31. Date filed (Month, Day, Year) FEB 09 2004			32. Registrar's Signature Benjamin B Sparks												

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

1- For Amend Item 10f per RH, 6828, 02/09/04
State of Maryland / Department of Health and Mental Hygiene
Certificate of Death

Reg. No. 2004 03534

Physician / Medical Examiner
Funeral Director

1. Decedent's Name (First, Middle, Last) ROBERT N. KARTMAN		2. Date of Death Month 2 Day 2004 Year		3. Time of Death 9:13 P M	
4a. Facility Name (If not institution, give street and number) SINAI HOSPITAL		4b. City, Town, or Location of Death BALTIMORE		4c. County of Death N/A	
5. Social Security Number 218-10-8994	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 84 Yrs.	8. Date of Birth (Month, Day, Year) FEB 18 1919		9. Birthplace (State or Foreign Country) MD

To Be Completed by Funeral Director

10a. State MD		10b. County BALTIMORE		10c. City, Town or Location OWINGS MILLS		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
10e. Street and Number 9050 IRON HORSE LANE #318		10f. Zip Code 21117 21208		10g. Citizen of What Country? USA			
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: WHITE	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <input type="checkbox"/> College (1-4 or 5+) <input checked="" type="checkbox"/>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) WHOLESALE		16b. Kind of Business/Industry CANDY & TOBACCO			
17. Father's Name (First, Middle, Last) I SADORE KARTMAN		18. Mother's Name (First, Middle, Maiden Surname) MILDRED COHEN					
19a. Informant's Name/Relationship (Type, Print) MRS. SHELLEY SANSFIELD/DAUGHTER		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 211 OWINGS GATE COURT #302 OWINGS MILLS, MD. 21117					
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) BALTIMORE HEBREW		Date 2/5/2004		20c. Location - City or Town, State REISTERSTOWN, MD.	
21. Signature of Funeral Service Licensee 		22. Name and Address of Facility SOL LEVINSON & BROS. INC. 8900 REISTERSTOWN ROAD PIKESVILLE, MD. 21208					

Physician / Medical Examiner
To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Ischemic CARDIOVASCULAR DISEASE		Approximate Interval Between Onset and Death	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last CHD ISCHEMIC CARDIOVASCULAR DISEASE			
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <input type="checkbox"/> Unknown	
23d. Date of delivery Month Day Year			
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.			
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)	
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year) 2/3/2004	
28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	
28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.			
29b. Signature and title of certifier 		29c. License number 3-20482	
29d. Date signed (Month, Day, Year) 2/3/2004			
30. Name and address of person completing cause of death (Item 23a) (Type, Print) 1838 S. BOWEN ST. #300 BALTIMORE MD 21205			
31. Date filed (Month, Day, Year) FEB 09 2004		32. Registrar's Signature 	

State Registrar

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2004 03535

1- For
State
RegistrarPhysician
/Medical
ExaminerFuneral
Director

1. Decedent's Name (First, Middle, Last) ALEXANDER WOJCIEK KLIMECKI			2. Date of Death Month January Day 27 Year 2004		3. Time of Death 9:33 P^M
4a. Facility Name (If not institution, give street and number) Washington County Hospital			4b. City, Town, or Location of Death Hagerstown		4c. County of Death Washington
5. Social Security Number 101-26-4533	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 83 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) April 8, 1920
9. Birthplace (State or Foreign Country) Poland					
Usual Residence of Decedent					
10a. State Maryland		10b. County Washington		10c. City, Town or Location Boonsboro	
10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
10e. Street and Number 8507 Mapleville Road			10f. Zip Code 21713		10g. Citizen of What Country? U.S.A
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:	
14. Race - American Indian, Black, White, etc. Specify: White					
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 7 College (1-4or 5+)			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Chemical Engineer		16b. Kind of Business/Industry Manufacturing Company
17. Father's Name (First, Middle, Last) Wladyslaw Klimecki			18. Mother's Name (First, Middle, Maiden Surname) Helena Lucka		
19a. Informant's Name/Relationship (Type, Print) Michele H. Vandover Daughter			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10406 Cold Harbor Drive, Hagerstown, Md. 21740		
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Smithsburg Crematorium		20c. Location - City or Town, State 01-29-04 Smithsburg, Maryland	
21. Signature of Funeral Service Licensee R. Noel Brady			22. Name and Address of Facility Andrew K. Coffman Funeral Home, Inc. 40 East Antietam Street, Hagerstown, Md. 21740		
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Fracture left femur					
Immediate Cause (Final disease or condition resulting in death) a. Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of):					
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last					
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (Specify) <input type="checkbox"/> Unknown		23d. Date of delivery Month Day Year	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. pneumonia, ischemic bowel, ASCVD				23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown	
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year) 01-08-04		28b. Time of Injury 3:30 P^M	
28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred fall at Fahrney Keedy Nursing Home			
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Fahrney Keedy Nursing Home		28f. Location (Street and Number or Rural Route Number, City or Town, State) 8507 Mapleville Rd. Boonsboro, Md.			
29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.					
29b. Signature and title of certifier Howard N. Weeks		29c. License number D0011266		29d. Date signed (Month, Day, Year) January 28, 2004	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Howard N. Weeks, MD 580 Northern Avenue, Hagerstown, Md. 21742					
31. Date filed (Month, Day, Year) FEB 09 2004		32. Registrar's Signature Kevin H. Smith			

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2004 03536

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

JUANITA LEMON

2. Date of Death
Month Day Year

1 20 2004

3. Time of Death

10:30AM

4a. Facility Name (If not institution, give street and number)

HOLY CROSS NURSING AND REHABILITATION HOME

4b. City, Town, or Location of Death

BURTONSVILLE

4c. County of Death

MONTGOMERY

Funeral
Director

5. Social Security Number

517-38-6623

6. Sex

☐ M ☒ F

7. Age (In yrs. last birthday)

89

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth
(Month, Day, Year)

JAN. 11, 1915

9. Birthplace (State or Foreign Country)

TEXAS

Usual Residence of Decedent

10a. State

MD

10b. County

MONTGOMERY

10c. City, Town or Location

BURTONSVILLE

10d. Inside City Limits

☐ Yes ☒ No

10e. Street and Number

3415 GREENCASTLE RD.

10f. Zip Code

20866

10g. Citizen of What Country?

U.S.A.

11. Marital Status

☐ Never Married ☐ Married☒ Widowed ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

☐ Yes ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

☐ Yes ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: WHITE

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

5+

16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired)

HOMEMAKER

16b. Kind of Business/Industry

OWNED HOME

17. Father's Name (First, Middle, Last)

FRED W. SPARWASSER

18. Mother's Name (First, Middle, Maiden Surname)

BERTHA T. WEBSTER

19a. Informant's Name/Relationship (Type, Print)

LAWRENCE LEMONT/SON

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

12807 SILVERBIRCH LN. LAUREL, MD 20708

20a. Method of Disposition

☐ Burial ☒ Cremation ☐ Removal from State☐ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

BALT.--WASH.--CREMATORY

Date

2-01-04 LAUREL, MD

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

FLECK FUNERAL HOME, INC.

7601 SANDY SPRING RD. LAUREL, MD 20707

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. BREAST CANCER

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

1 YEAR

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

DEMENTIA

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☒ No ☐ Probably ☐ Unknown

24a. Was an autopsy performed?

☐ Yes ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

☐ Yes ☐ No

25. Was case referred to medical examiner?

☐ Yes ☒ No

Hospital:

☐ Inpatient☐ ER/Outpatient☐ DOA

26. Place of Death (Check only one)

Other:

☒ Nursing Home ☐ Residence ☐ Other (Specify)

27. Manner of Death

☒ Natural☐ Accident☐ Suicide☐ Homicide☐ Pending investigation☐ Could not be determined28a. Date of Injury
(Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

☐ Yes ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier
(Check only one)☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D43237

29d. Date signed (Month, Day, Year)

JANUARY 20, 2004

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

PAUL ARMSTRONG, M.D. 14201 LAUREL PARK DR. # 102 LAUREL, MD 20707

31. Date filed (Month, Day, Year)

FEB 09 2004

32. Registrar's Signature

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
ExaminerTo the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

State of Maryland / Department of Health and Mental Hygiene 2001

1- For State Registrar Amend Item #2 per PHYG828 2/17/04 EW *Certificate of Death*

1. Decedent's Name (First, Middle, Last) Maey Ellen Lind	2. Date of Death Feb 4 2004 Month Day Year	3. Time of Death 2:00 A.M.
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4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Bilchoist	Towson	BALTIMORE

5. Social Security Number 310-10-4387	6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 87 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) 12-27-16	9. Birthplace (State or Foreign Country) Indiana
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Usual Residence of Decedent			
10a. State MD	10b. County HARFORD	10c. City, Town or Location FOREST HILL	10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No

10e. Street and Number 313 Coatsford Way	10f. Zip Code 31050	10g. Citizen of What Country? USA
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11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:	14. Race - American Indian, Black, White, etc. Specify: white.
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15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12) 12	College (1-4or 5+) 2.	Optical Engineer	RCA

17. Father's Name (First, Middle, Last) William Ralph Wilder

19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
 KAREN L. BRAUER. 212 Orchard Way, Forest Hill, MD 21050.

20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)	20b. Place of Disposition (Name of cemetery, crematory or other place) EVANS, BEL HIRSH EVANS, BEL HIRSH - 3-7-14	Date 3-7-14	20c. Location - City or Town, State FOREST HILL, OH
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21. Signature of Funeral Service Licensee *[Signature]* 22. Name and Address of Facility *3 NEWPORT DR, FOREST HILL, MD*

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.	Approximate Interval Between Onset and Death
23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.	Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death) a. Lewy Body Dementia 4 years
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying

b. Due to (or as a consequence of):

Cause (Disease or injury that initiated events resulting in death) Last	c. _____ Due to (or as a consequence of):	
---	--	--

	d.	

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes, 2 ☒ No

23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death

3 ☐ Ectopic pregnancy
5 ☐ Other (specify) _____

23d. Date of delivery
Month _____ Day _____ Year _____

9 <input type="checkbox"/> Unknown	9 <input type="checkbox"/> Unknown	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?		24b. Were autopsy findings available prior to completion of cause of death?	
1 <input checked="" type="checkbox"/> Yes	2 <input type="checkbox"/> No	1 <input type="checkbox"/> Yes	2 <input checked="" type="checkbox"/> No


25. Was case referred to medical examiner?
1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)
Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA
Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☒ Other (Specify) HOSPICE

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 5 <input type="checkbox"/> Pending investigation		M	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	

3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide	6 <input type="checkbox"/> Could not be determined	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)
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29a. Certifier (Check only one) ☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier 	29c. License number D 58217	29d. Date signed (Month, Day, Year) Feb 04 4 2004
--	--------------------------------	--

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
 Azrael Charles [signature] 1401 N. Charles St. Brea, CA 92603

31. Date filed (Month, Day, Year)	32. Registrar's Signature
-----------------------------------	---------------------------

FEB 09 2004 *Penava B Sparks*
ORIGINAL

ORIGINAL

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2004 03538

1- For
State
Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Gladys Lorraine Lattimore				2. Date of Death Month 01 Day 31 Year 2004		3. Time of Death 330p M	
	4a. Facility Name (If not institution, give street and number) Mercy Medical Center				4b. City, Town, or Location of Death Baltimore		4c. County of Deeth	
Funeral Director	5. Social Security Number 219-28-0305		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 69 Yrs.		8. Date of Birth (Month, Day, Year) Feb. 19, 1934	
	9. Birthplace (State or Foreign Country) Maryland		10a. State Maryland		10b. County N/A		10c. City, Town or Location Baltimore	
To Be Completed by Funeral Director	10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		10e. Street and Number 1015 N. Kenwood Ave.		10f. Zip Code 21205		10g. Citizen of What Country? USA	
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: Black	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12th Grade College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Office Assistant		16b. Kind of Business/Industry Greybar Electric Co.			
	17. Father's Name (First, Middle, Last) Asbury Robinson				18. Mother's Name (First, Middle, Maiden Surname) Essie Mae Williams			
	19a. Informant's Name/Relationship (Type, Print) Cynthia Lattimore-daughter				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1015 N. Kenwood Ave. Baltimore Maryland 21205			
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Garrison Forest Vet. Cem		20c. Location - City or Town, State 2/6/04 Owings Mills, Maryland			
	21. Signature of Funeral Service Licensee Kevin Parker		22. Name and Address of Facility Farker Chevis & Crematory F.S. P.A. 3512 Frederick Ave. Baltimore, Maryland 21229					
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Colon Adenocarcinoma							
	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of):							
	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 9 <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) 9 <input type="checkbox"/> Unknown				23d. Date of delivery Month Day Year	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown		
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)						
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
		28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				
28f. Location (Street and Number or Rural Route Number, City or Town, State)								
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier Nikkita Pessa, MD		29c. License number P16485		29d. Date signed (Month, Day, Year) 01/31/2004		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Nikkita Pessa MD 301 St. Paul Place Baltimore, Maryland 21202								
31. Date filed (Month, Day, Year) FEB 09 2004		32. Registrar's Signature [Signature]						

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

10

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene
 1- For Amend Items 24a, 25, 26, 27, 29a, 30 per Dr. G828 02/09/04dhb
 Registrar Certificate of Death Reg. No. 2004 03539

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Physician /Medical Examiner

Funeral Director

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

1. Decedent's Name (First, Middle, Last) Judith LaChance		2. Date of Death Month Day Year January 23, 2004		3. Time of Death 12:00 PM	
4a. Facility Name (If not institution, give street and number) Holy Cross Hospital		4b. City, Town, or Location of Death Silver Spring		4c. County of Death Montgomery	
5. Social Security Number 110-28-0107		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 68 Yrs.	
8. Date of Birth (Month, Day, Year) Jan 30, 1935		9. Birthplace (State or Foreign Country) New York			
Usual Residence of Decedent					
10a. State MD		10b. County Montgomery		10c. City, Town or Location Silver Spring	
10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No					
10e. Street and Number 8600 16th Street #1007		10f. Zip Code 20910		10g. Citizen of What Country? USA	
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:	
14. Race - American Indian, Black, White, etc. Specify: white					
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 4		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) secretary		16b. Kind of Business/Industry DC government	
17. Father's Name (First, Middle, Last) Harry Solon		18. Mother's Name (First, Middle, Maiden Surname) Rebekah Weisman			
19a. Informant's Name/Relationship (Type, Print) Ronald Johnson/spouse		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8600 16th Street #1007 Silver Spring, MD 20910			
20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input checked="" type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Date		20c. Location - City or Town, State	
21. Signature of Funeral Service Licensee Ronald S. Wade, Director		22. Name and Address of Facility State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. cirrhosis of liver with portal hypotension and Due to (or as a consequence of): b. lung mass Due to (or as a consequence of): c. hepatitis C infection Due to (or as a consequence of): d. Approximate Interval Between Onset and Death					
23b. IF FEMALE: Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 9 <input type="checkbox"/> Unknown					
23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) 9 <input type="checkbox"/> Unknown					
23d. Date of delivery Month Day Year					
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.					
23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown					
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No					
24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No					
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M	
28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred			
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.					
29b. Signature and title of certifier Paytel Jayanti, M.D.		29c. License number D-0052586		29d. Date signed (Month, Day, Year) January 23, 2004	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Paytel Jayanti, MD, Holy Cross Hospital, 1500 Forest Glen Pkwy., Maryland					
31. Date filed (Month, Day, Year) FEB 09 2004		32. Registrar's Signature [Signature]			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2004 03540

1- For
State
RegistrarPhysician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

JOHN HENRY LOWMAN JR.

2. Date of Death

February 04, 2004 10:35 PM

3. Time of Death

Funeral
Director

4a. Facility Name (If not institution, give street and number)

Saint Joseph Medical Center

4b. City, Town, or Location of Death

Towson

4c. County of Death

Baltimore

5. Social Security Number

218-24-1629

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

74 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

June 28, 1929

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Washington

10c. City, Town or Location

Hagerstown

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

7 East Washington Street

10f. Zip Code

21740

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☒ Never Married 2 ☐ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: White

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

9

College (1-4or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Laborer

16b. Kind of Business/Industry

Janitorial Service

17. Father's Name (First, Middle, Last)

John Henry Lowman Jr.

18. Mother's Name (First, Middle, Maiden Surname)

Irene Elizabeth Gross

19a. Informant's Name/Relationship (Type, Print)

Penelope A. Marks Sister

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

723 Maryland Avenue, Hagerstown, Md. 21740

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Rose Hill Cemetery

Date

02-10-04

20c. Location - City or Town, State

Hagerstown, Maryland

21. Signature of Funeral Service Licensee

R. Todd Brady

22. Name and Address of Facility

Andrew K. Coffman Funeral Home, Inc.
40 East Antietam St., Hagerstown, Maryland 2174023a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

Acute Myocardial Infarction

Approximate
Interval Between
Onset and Death

1 Hour

a. Due to (or as a consequence of):

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

IF FEMALE:

23b. Was decedent pregnant
in the past 12 months?1 ☐ Yes 2 ☐ No
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy
4 ☐ Pregnant at time of death 5 ☐ Other (specify)
9 ☐ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an
autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings available
prior to completion of cause of
death?1 ☐ Yes 2 ☒ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending
investigation
2 ☐ Accident 6 ☐ Could not be
determined
3 ☐ Suicide 4 ☐ Homicide28a. Date of Injury
(Month, Day Year)28b. Time of
Injury28c. Injury at
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
and manner stated.

29b. Signature and title of certifier

Mark G. Midei

29c. License number

D 30042

29d. Date signed (Month, Day, Year)

02/05/04

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Mark Midei, M.D., 7601 Osler Drive Towson, Maryland 21204

31. Date filed (Month, Day, Year)

FEB 09 2004

32. Registrar's Signature

[Signature]

Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit
once.Physician
/Medical
Examiner

To Be Completed by Funeral Director

Medical Certification; To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit
once.State
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2004 03541

1- For State Registrar

Physician / Medical Examiner	1. Decedent's Name (First, Middle, Last) WILLIAM BOOTH McMILLAN			2. Date of Death Month 2 Day 3 Year 2004		3. Time of Death 2:30 PM		
	4a. Facility Name (If not institution, give street and number) FRANKLIN SQUARE Hospital			4b. City, Town, or Location of Death ROSCDALE		4c. County of Death BALTIMORE		
Funeral Director	5. Social Security Number 151-01-7512		6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F	7. Age (In yrs. last birthday) 89 Yrs.		8. Date of Birth (Month, Day, Year) 1 15 1915		
	9. Birthplace (State or Foreign Country) PENNSYLVANIA							
To Be Completed by Funeral Director	Usual Residence of Decedent							
	10a. State MARYLAND		10b. County BALTIMORE		10c. City, Town or Location PARKVILLE		10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
	10e. Street and Number 8820 WALTHER BLVD.			10f. Zip Code 21234		10g. Citizen of What Country? U.S.A.		
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates: WWII		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: WHITE	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 2			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) ELECTRICAL ENGINEER		16b. Kind of Business/Industry ELECTRONICS		
	17. Father's Name (First, Middle, Last) WILLIAM J. McMILLAN			18. Mother's Name (First, Middle, Maiden Surname) MARY CRAIG				
	19a. Informant's Name/Relationship (Type, Print) EMMA E. McMILLAN / WIFE			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8820 WALTHER BLVD., PARKVILLE, MD 21234				
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) GARRISON FOREST VETERAN'S CEMETERY		Date FEB 11, 2004		20c. Location - City or Town, State GARRISON, MARYLAND	
	21. Signature of Funeral Service Licensee Kimberly J. Ruston			22. Name and Address of Facility EVANS FUNERAL CHAPEL 8800 HARFORD RD., PARKVILLE, MD 21234				
	Physician / Medical Examiner	23a. Part I. Enter the disease(s), or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Aspiration Pneumonia Due to (or as a consequence of): b. Renal Insufficiency Due to (or as a consequence of): c. Anemia Due to (or as a consequence of): d.						Approximate Interval Between Onset and Death
23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 9 <input type="checkbox"/> Unknown						23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) 9 <input type="checkbox"/> Unknown		
23d. Date of delivery Month Day Year								
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								
23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown								
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No						
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28d. Describe how injury occurred					
28f. Location (Street and Number or Rural Route Number, City or Town, State)								
State Registrar	29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
	29b. Signature and title of certifier Kenneth McDowell		29c. License number H-58010		29d. Date signed (Month, Day, Year) 2-3-2004			
	30. Name and Address of person who completed cause of death (Item 23a) (Type/Print) DR Kenneth McDowell 9000 FRANKLIN SQUARE DR, BALTIMORE Md 21237							
	31. Date filed (Month, Day, Year) FEB 09 2004		32. Registrar's Signature Sparks					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

1- For State Registrar

2004 03542

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Russell A. Marsh, Sr.				2. Date of Death Month Day Year February 4, 2004		3. Time of Death 7:37 A ^M	
	4a. Facility Name (If not institution, give street and number) 7959 Telegraph Road, Lot #104				4b. City, Town, or Location of Death Severn		4c. County of Death Anne Arundel	
Funeral Director	5. Social Security Number 578-46-8055	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs, last birthday) 67 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) 2/03/1937		9. Birthplace (State or Foreign Country) Virginia
	Usual Residence of Decedent							
To Be Completed by Funeral Director	10a. State MD	10b. County Anne Arundel		10c. City, Town or Location Severn			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	10e. Street and Number 7959 Telegraph Road, Lot #104				10f. Zip Code 22144		10g. Citizen of What Country? U.S.A.	
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Sales		16b. Kind of Business/Industry Rowan Heating & Airconditioning			
	17. Father's Name (First, Middle, Last) Russell Marsh				18. Mother's Name (First, Middle, Maiden Surname) Nellie Frances McColley			
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) Elizabeth Marsh, Wife				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7959 Telegraph Road, Lot #104 Severn, MD 22144			
	20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Balt-Wash. Crematory		Date 02/08/2004		20c. Location - City or Town, State Laurel, Maryland	
	21. Signature of Funeral Service Licensee <i>Kanya Stewart</i>				22. Name and Address of Facility Fleck Funeral Home, Inc. 7601 Sandy Spring Road, Laurel, Maryland 20707			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Myocardial Infarction Due to (or as a consequence of): b. Ventricular Fibrillation Due to (or as a consequence of): c. Coronary Artery Disease Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last							
	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Unknown		3 Ectopic pregnancy 5 Other (specify)		23d. Date of delivery Month Day Year	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No						
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)						
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
29b. Signature and title of certifier <i>Steven T. Tee</i>				29c. License number D46998		29d. Date signed (Month, Day, Year) February 6, 2004		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) STEVEN T. TEE MD 3415 HAMILTON ST HYATTSTVILLE MD 20782								
31. Date filed (Month, Day, Year) FEB 09 2004		32. Registrar's Signature <i>[Signature]</i>						

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural," or items 23e or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be completed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

Certificate of Death

Reg. No.

2004 03543

Physician
/Medical
ExaminerFuneral
Director

1. Decedent's Name (First, Middle, Last)

Michael Robert Marcopulos, Sr.

2. Date of Death

February 4, 2004

3. Time of Death

12:20 A

4a. Facility Name (If not institution, give street and number)

St. Mary's Nursing Center

4b. City, Town, or Location of Death

Leonardtown

4c. County of Death

St. Mary's

5. Social Security Number

577-05-9972

6. Sex

XXM 2□F

7. Age (In yrs. last birthday)

88

Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

01/04/1916

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Prince George's

10c. City, Town or Location

Ft. Washington

10d. Inside City Limits

1□Yes 2□No

10e. Street and Number

13105 Monroe Avenue

10f. Zip Code

20744

10g. Citizen of What Country?

USA

11. Marital Status

1□Never Married 2□Married

3□Widowed 4□Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1□Yes 2□No

If Yes, Give

Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1□Yes 2□No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: White

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

Warehouse Supervisor

16b. Kind of Business/Industry

Retail Food/Safeway

17. Father's Name (First, Middle, Last)

Theodore Marcopulos

18. Mother's Name (First, Middle, Maiden Surname)

Mabel Lynch

19a. Informant's Name/Relationship (Type, Print)

Jean O'Leary / Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

13105 Monroe Avenue Ft. Washington, Maryland 20744

20a. Method of Disposition

1□Burial 2□Cremation 3□Removal from State

4□Donation 5□Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Wash. Nat'l. Cemetery

Date

02/09/2004

20c. Location - City or Town, State

Suitland, Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

George P. Kalas Funeral Home P.A.
6160 Oxon Hill Road Oxon Hill, Maryland 20745

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate
Interval Between
Onset and DeathImmediate Cause (Final
disease or condition
resulting in death)e. Cardiopulmonary Failure

Due to (or as a consequence of):

b. Renal Failure

Due to (or as a consequence of):

c. Generalized Arteriosclerosis

Due to (or as a consequence of):

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

d. _____

hrs
days
yrs

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Dementia

23b. Did tobacco use contribute to the cause of death?

1□Yes 2□No 3□Probably 4□Unknown

24a. Was an autopsy
performed?

1□Yes 2□No

24b. Were autopsy findings
available prior to
completion of cause
of death?

1□Yes 2□No

25. Was case referred to medical
examiner?

1□Yes 2□No

Hospital:

1□Inpatient

2□ER/Outpatient

3□DOA

Other:

4□Nursing Home

5□Residence

6□Other (Specify)

27. Manner of Death

1□Natural

2□Accident

3□Suicide

4□Homicide

5□Pending
Investigation6□Could not be
determined

28a. Date of Injury

(Month, Day Year)

28b. Time of

Injury

M

28c. Injury at

Work?

1□Yes 2□No

28d. Describe how injury occurred

29a. Certifier
(Check only
one)

1□Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2□Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

Md. D06419

29d. Date signed (Month, Day, Year)

2-4-04

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

James P. Jarboe MD

Philip Bean Med. Ctr. P.O. Box 64 Hollywood, Maryland 20636

31. Date filed (Month, Day, Year)

FEB 09 2004

32. Registrar's Signature

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show
any injury or other traumatic event, the Medical Examiner must be notified at
0036.Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2004 03544

1- For
State
RegistrarPhysician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Thomas J. McFarland, Jr.

2. Date of Death

Month Day Year
January 31, 2004

3. Time of Death

4:50 A M

4a. Facility Name (If not institution, give street and number)

3734 Patuxent Manor Rd.

4b. City, Town, or Location of Death

Davidsonville

4c. County of Death

Anne Arundel

Funeral
Director

5. Social Security Number

183-26-8589

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

67

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
Nov. 17, 1936

9. Birthplace (State or Foreign Country)

Pennsylvania

Usual Residence of Decedent

10a. State

Maryland

10b. County

Anne Arundel

10c. City, Town or Location

Davidsonville

10d. Inside City Limits

☐ Yes ☒ No

10e. Street and Number

3734 Patuxent Manor Rd.

10f. Zip Code

21035

10g. Citizen of What Country?

USA

11. Marital Status

☐ Never Married ☒ Married
☐ Widowed ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
☒ Yes ☐ No
If Yes, Give
Year or Dates: 1954-5613. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)☐ Yes ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: White

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12th

College (1-4or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working
life. DO NOT use retired)

Police Officer

16b. Kind of Business/Industry

Law Enforcement

17. Father's Name (First, Middle, Last)

Thomas James McFarland

18. Mother's Name (First, Middle, Maiden Surname)

Mary Montague

19a. Informant's Name/Relationship (Type, Print)

Joan C. McFarland/ Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

3734 Patuxent Manor Rd., Davidsonville, MD 21035

20a. Method of Disposition

☒ Burial ☐ Cremation ☐ Removal from State
☐ Donation ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Lakemont Cemetery

Date

2-4-04

20c. Location - City or Town, State

Davidsonville, MD

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

George P. Kalas Funeral Home
2973 Solomons Island Rd. Edgewater, MD 2103723a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

a. CONGESTIVE HEART FAILURE

Due to (or as a consequence of):

b. CORONARY ARTERY DISEASE

Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) LastApproximate
Interval Between
Onset and Death

IF FEMALE:

23b. Was decedent pregnant
in the past 12 months?☐ Yes ☒ No
☐ Unknown

23c. If yes, outcome of pregnancy

☐ Live birth ☐ Fetal death ☐ Ectopic pregnancy
☐ Pregnant at time of death ☐ Other (specify)
☐ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

MALIGNANT CARCINOID TUMOR

23e. Did tobacco use contribute to the cause of death?

☐ Yes ☒ No ☐ Probably ☒ Unknown24a. Was an
autopsy
performed?☐ Yes ☒ No24b. Were autopsy findings available
prior to completion of cause of
death?☐ Yes ☒ No25. Was case referred to medical
examiner?☐ Yes ☒ No

Hospital:

☐ Inpatient ☒ ER/Outpatient ☐ DOA

Other:

☐ Nursing Home ☒ Residence ☐ Other (Specify)

27. Manner of Death

☒ Natural ☐ Pending investigation
☐ Accident ☐ Could not be determined
☐ Suicide ☐ Homicide

28a. Date of Injury

(Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

☐ Yes ☒ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D16364

29d. Date signed (Month, Day, Year)

2/2/04

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

PETER R. GRADE MD 900 BOSTON RD 300 ANNAPOLIS MD 21401

31. Date filed (Month, Day, Year)

FEB 09 2004

32. Registrar's Signature

State
Registrar

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show
any injury or other traumatic event, the Medical Examiner must be notified at
once.Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed
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To the Funeral Director: After this certificate has been signed by the attending physician and
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Medical Certification; To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2004 03545

1- For
State
Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) James H. Mayberry				2. Date of Death Month Day Year February 5, 2004		3. Time of Death 8:07 P M	
	4a. Facility Name (If not institution, give street and number) Laurel Regional Hospital				4b. City, Town, or Location of Death Laurel		4c. County of Death Prince Georges	
Funeral Director	5. Social Security Number 205-32-1591		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 61 Yrs.		8. Date of Birth (Month, Day, Year) 12/25/1942	
	9. Birthplace (State or Foreign Country) Pennsylvania		10a. State MD		10b. County Howard		10c. City, Town or Location Laurel	
To Be Completed by Funeral Director	10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		10e. Street and Number #8 Pfister Street		10f. Zip Code 20723		10g. Citizen of What Country? U.S.A.	
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 2		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Entrepreneur		16b. Kind of Business/Industry Commercial Construction			
	17. Father's Name (First, Middle, Last) H. L. Mayberry				18. Mother's Name (First, Middle, Maiden Surname) Betty Switzer			
	19a. Informant's Name/Relationship (Type, Print) Tamara A. Mayberry-Isman, Daughter				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20006 Canebroke Court, Gaithersburg, MD 20886			
	20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Balt-Wash Crematory		Date 2/09/2004		20c. Location - City or Town, State Laurel, Maryland	
	21. Signature of Funeral Service Licensee 		22. Name and Address of Facility Fleck Funeral Home, Inc. 7601 Sandy Spring Road, Laurel, Maryland 20707					
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Cerebrovascular Accident Due to (or as a consequence of): b. Cardiorespiratory Failure Due to (or as a consequence of): c. Renal Insufficiency Due to (or as a consequence of): d. Approximate Interval Between Onset and Death 4 days 1 hour 6 months							
	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Unknown <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Other (specify)		23d. Date of delivery Month Day Year			
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown	
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No						
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
28d. Describe how injury occurred		28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
29b. Signature and title of certifier 		29c. License number D20727		29d. Date signed (Month, Day, Year) 2-7-04				
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) R. Gupta, M.D. 7215-D Hanover Parkway, Greenbelt, Maryland 20770								
31. Date filed (Month, Day, Year) FEB 09 2004		32. Registrar's Signature 						

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Division of Vital Records, P.O. Box 68760,

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2004 03546

1- For
State
Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <i>Byrdie L. Mills</i>			2. Date of Death Month <i>Feb</i> Day <i>6</i> Year <i>2004</i>			3. Time of Death <i>12³⁰ PM</i>		
	4a. Facility Name (If not institution, give street and number) <i>222 E. Lafayette Ave.</i>			4b. City, Town, or Location of Death <i>Baltimore</i>			4c. County of Death <i>a/s</i>		
Funeral Director	5. Social Security Number <i>212-14-7083</i>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <i>97</i> Yrs.		8. Date of Birth (Month, Day, Year) <i>10-3-1906</i>		9. Birthplace (State or Foreign Country) <i>South Carolina</i>	
	Usual Residence of Decedent								
10a. State <i>MD</i>		10b. County <i>N/A</i>		10c. City, Town or Location <i>Baltimore</i>				10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
10e. Street and Number <i>222 E. Lafayette Ave</i>				10f. Zip Code <i>21202</i>		10g. Citizen of What Country? <i>U.S.A.</i>			
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <i>Black</i>	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <i>12</i> College (1-4 or 5+) <i></i>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <i>nurse</i>			16b. Kind of Business/Industry <i>medical</i>		
17. Father's Name (First, Middle, Last) <i>George Jenkins</i>				18. Mother's Name (First, Middle, Maiden Surname) <i>Minerva Washington</i>					
19a. Informant's Name/Relationship (Type, Print) <i>Regina Mason daughter</i>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>222 E. Lafayette Ave. Balt. Md. 21202</i>					
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) <i>MD. National Home Park</i>			20c. Location - City or Town, State <i>Feb 12 2004 Laurel, Md.</i>			
21. Signature of Funeral Service Licensee <i>Carlton C. Douglas</i>			22. Name and Address of Facility <i>Carlton C. Douglas Funeral Service P.A. 1701 Mc Culloch St. Balto. W. 21217</i>						
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) <i>ALZHEIMER DEMENTIA</i> Sequentially list conditions, if any, leading to immediate cause. Enter underlying cause (Disease or injury that initiated events resulting in death) Last <i>HYPERTENSION</i> <i>DIABETES MELLITUS</i>									Approximate Interval Between Onset and Death
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown			23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <input checked="" type="checkbox"/> Unknown			23d. Date of delivery Month Day Year			
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown			
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined			28a. Date of Injury (Month, Day Year)		28b. Time of Injury <i>M</i>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred
			28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.			29b. Signature and title of certifier <i>ATTENDING PHYSICIAN</i>			29c. License number <i>DOO 56948</i>		29d. Date signed (Month, Day, Year) <i>FEB 9th 2004</i>	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <i>JAMES TANSINDA 522 DOLPHIN STREET BALTIMORE MD</i>									
31. Date filed (Month, Day, Year) <i>FEB 09 2004</i>			32. Registrar's Signature <i>James H. Jones</i>						

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification; To Be Completed by Physician/Medical Examiner

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2004 03547

Physician
/Medical
Examiner

Funeral
Director

1. Decedent's Name (First, Middle, Last) Estelle J. Moreland				2. Date of Death Month February Day 6 Year 2004		3. Time of Death 9:30 am	
4a. Facility Name (If not institution, give street and number) Laurelwood Care Center				4b. City, Town, or Location of Death Elkton		4c. County of Death Cecil	
5. Social Security Number 222-09-0398		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 81 Yrs.		8. Date of Birth (Month, Day, Year) Dec. 27, 1921	
9. Birthplace (State or Foreign Country) Delaware		10a. State Maryland		10b. County Cecil		10c. City, Town or Location Elkton	
10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		10e. Street and Number 100 Laurel Drive		10f. Zip Code 21921		10g. Citizen of What Country? United States	
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No Specify: Puerto Rican		14. Race - American Indian, Black, White, etc. Specify: White	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12th College (1-4or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Waitress		16b. Kind of Business/Industry Food Service			
17. Father's Name (First, Middle, Last) Michael Albanse				18. Mother's Name (First, Middle, Maiden Surname) Nola Fernandez			
19a. Informant's Name/Relationship (Type, Print) Barbara Sayers/ Daughter				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 40 Union Valley Road Elkton, Maryland 21921			
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) West Arundel Crematory		20c. Date 2/10/2004		20d. Location - City or Town, State Odenton, Maryland	
21. Signature of Funeral Service Licensee Quantia R Thomas		22. Name and Address of Facility Anatomy Gift Registry		22b. Address 7526 Connelley Dr. Suite E. Hanover, Maryland 21076			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) CHANGE IN MENTAL STATUS Due to (or as a consequence of): CVA Due to (or as a consequence of): DM Due to (or as a consequence of): END STAGE DEMENTIA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last							
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown							
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No							
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No							
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No	
28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. Signature and title of certifier [Signature]				29c. License number DS4073		29d. Date signed (Month, Day, Year) 06 FEB 04	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ARION STONE, MD 817 CHURCHMAN'S CTR NEW CASTLE DE 19720							
31. Date filed (Month, Day, Year) FEB 9 2004				32. Registrar's Signature [Signature]			

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Physician
/Medical
Examiner

2

State
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

1- Amend Item 21, 24aper Dvr/Dr., G828, 02/08/04dhb
State of Maryland / Department of Health and Mental Hygiene
Certificate of Death

Reg. No.

2004 03548

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Maria M. Magtibay			2. Date of Death Month January Day 7 Year 2004			3. Time of Death 9:20p^M			
	4a. Facility Name (If not institution, give street and number) 9600 Northwind Road			4b. City, Town, or Location of Death Baltimore			4c. County of Death Baltimore			
Funeral Director	5. Social Security Number 219-94-1554		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 87 Yrs.		8. Date of Birth (Month, Day, Year) Dec. 8, 1916		9. Birthplace (State or Foreign Country) Philippines	
	Usual Residence of Decedent									
10a. State MD		10b. County Baltimore		10c. City, Town or Location Baltimore				10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
10e. Street and Number 9600 Northwind Road				10f. Zip Code 21234			10g. Citizen of What Country? USA			
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: Filipino		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12th Grade College (1-4 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Retailer			16b. Kind of Business/Industry Self-Employed Retailer			
17. Father's Name (First, Middle, Last) Luis Maderazo				18. Mother's Name (First, Middle, Maiden Surname) Juana Apuntar						
19a. Informant's Name/Relationship (Type, Print) Mrs. Sionie Geronimo (daughter)				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9600 Northwind Road, Baltimore, MD 21234						
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) Dulaney Valley Mem'l			Date 1/12/04		20c. Location - City or Town, State Timonium, MD		
21. Signature of Funeral Service Licensee ► Brian Lewis per DVR				22. Name and Address of Facility Schimunek Funeral Homes 9705 Belair Rd., Baltimore, MD 21236						
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequitally list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last									Approximate Interval Between Onset and Death	
<div style="display: flex; align-items: center;"> <div style="font-size: 4em; margin-right: 10px;">{</div> <div> <p>a. acute myocardial infarction</p> <p>b. CORONARY ARTERY DISEASE</p> <p>c. ASCVD</p> <p>d. Type I D. Mellitus</p> </div> </div>									<p>immediate</p> <p>years</p> <p>years</p> <p>years</p>	
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 9 <input type="checkbox"/> Unknown			23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify)			23d. Date of delivery Month Day Year				
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. HYPER TENSION CUA, Rt Hemiplegia									23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown	
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)							
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide			28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred	
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.			29b. Signature and title of certifier ► [Signature]			29c. License number D17679		29d. Date signed (Month, Day, Year) 1/9/04		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Agaton H. Escalante, MD 8870 Belair Rd., Baltimore, MD 21236										
31. Date filed (Month, Day, Year) FEB 09 2004			32. Registrar's Signature [Signature]							

Baltimore, Maryland 21215-0036
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 905a.

Division of Vital Records, P.O. Box 68760,
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2004 03549

1- For
State
RegistrarPhysician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

ANNA J. MATEJSKI

2. Date of Death

Month Day Year
FEB. 1, 2004

3. Time of Death

12:10 P M

Funeral
Director

4a. Facility Name (If not institution, give street and number)

GENESIS ELDERCARE

4b. City, Town, or Location of Death

DUNDALK

4c. County of Death

BALTIMORE

5. Social Security Number

216-05-9460

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

91 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
JULY 7, 1912

9. Birthplace (State or Foreign Country)

MD.

Usual Residence of Decedent

10a. State

MD.

10b. County

N/A

10c. City, Town or Location

BALTIMORE

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

635 S. EATON STREET

10f. Zip Code

21224

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☐ No
If Yes, Give X Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

8TH

College (1-4or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

FACTORY WORKER

16b. Kind of Business/Industry

UNKNOWN

17. Father's Name (First, Middle, Last)

JOHN BRODKA

18. Mother's Name (First, Middle, Maiden Surname)

FRONIE

19a. Informant's Name/Relationship (Type, Print)

TINA A. HALL/GUARDIAN

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

519 S. SHARP ST., BALTIMORE, MARYLAND 21201

20a. Method of Disposition

1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

HOLY ROSARY CEMETERY

Date

2/6/04

20c. Location - City or Town, State

BALTIMORE, MARYLAND

21. Signature of Funeral Service Licensee

▶ *Deborah L. Hannon*

22. Name and Address of Facility

CHARLES S. ZEILER & SON, INC.

6224 EASTERN AVE., BALTIMORE, MARYLAND 21224

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. *ATHEROSCLEROTIC CARDIOVASCULAR DISEASE*

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. *HYPERTENSION*

Due to (or as a consequence of):

c. *HYPOTHYROIDISM*

Due to (or as a consequence of):

d. *MALNUTRITION*

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☒ No
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 5 ☐ Other (Specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

DEMENTIA

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ OOA

Other:

4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

▶ *Savinder K. Tane MD*

29c. License number

D27188

29d. Date signed (Month, Day, Year)

2/1/04

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Savinder K. Tane 2 Market Place Dundalk MD 21222

31. Date filed (Month, Day, Year)

FEB 09 2004

32. Registrar's Signature

▶ *[Signature]*

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
ExaminerTo the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2004 03550

1- For
State
RegistrarPhysician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

GLENN LOUIS MORRISON

2. Date of Death

January 25, 2004

3. Time of Death

11:20 AM

Funeral
Director

4a. Facility Name (If not institution, give street and number)

Washington County Hospital

4b. City, Town, or Location of Death

Hagerstown

4c. County of Death

Washington

5. Social Security Number

173-05-4217

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

92

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min

8. Date of Birth

December 17, 1911

9. Birthplace (State or Foreign Country)

Kansas

Usual Residence of Decedent

10a. State

Maryland

10b. County

Washington

10c. City, Town or Location

Hagerstown

10d. Inside City Limits

☒ Yes ☐ No

10e. Street and Number

1158 Luther Drive

10f. Zip Code

21740

10g. Citizen of What Country?

U.S.A.

11. Marital Status

☐ Never Married ☒ Married
☐ Widowed ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

☒ Yes ☐ No
If Yes, Give Year or Dates: WWII

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

☐ Yes ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4or 5+)

4

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Accountant

16b. Kind of Business/Industry

Printing Company

17. Father's Name (First, Middle, Last)

Merton Leon Morrison

18. Mother's Name (First, Middle, Maiden Surname)

Iva Moxley

19a. Informant's Name/Relationship (Type, Print)

Virginia G. Morrison Wife 1158 Luther Drive, Hagerstown, Maryland 21740

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

20a. Method of Disposition

☐ Burial ☒ Cremation ☐ Removal from State
☐ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Smithsburg Crematorium

Date

01-29-04

20c. Location - City or Town, State

Smithsburg, Maryland

21. Signature of Funeral Service Licensee

R. Noel Brady

22. Name and Address of Facility

Andrew K. Coffman Funeral Home, Inc.
40 East Antietam St., Hagerstown, Md. 21740

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Due to (or as a consequence of):

Sepsis

b. Due to (or as a consequence of):

Pneumonia

c. Due to (or as a consequence of):

Cerebral Vascular Accident

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

1 day

2-3 days

5-6 days

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

☐ Yes ☒ No
☐ Unknown

23c. If yes, outcome of pregnancy

☐ Live birth ☐ Fetal death ☐ Ectopic pregnancy
☐ Pregnant at time of death ☐ Other (Specify)
☐ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Hypertension chronic obstructive pulmonary disease
Alcohol Dementia

23e. Did tobacco use contribute to the cause of death?

☐ Yes ☒ No ☐ Probably ☐ Unknown

24a. Was an autopsy performed?

☐ Yes ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

☐ Yes ☒ No

25. Was case referred to medical examiner?

☐ Yes ☒ No

Hospital:

☒ Inpatient☐ ER/Outpatient☐ DOA

Other:

☐ Nursing Home☐ Residence☐ Other (Specify)

27. Manner of Death

☒ Natural ☐ Pending investigation
☐ Accident ☐ Could not be determined
☐ Suicide ☐ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

☐ Yes ☒ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

[Signature]

29c. License number

D18019

29d. Date signed (Month, Day, Year)

Jan 26, 2004

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

VASANT DATTA MD 340 MILL ST HAGERSTOWN MD 21740

31. Date filed (Month, Day, Year)

FEB 09 2004

32. Registrar's Signature

[Signature]

ORIGINAL

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
ExaminerTo the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner


Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2004 03551

1- For
State
Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Jerimiah Moultrie				2. Date of Death Month February Day 3rd Year 2004		3. Time of Death 7-35PM	
	4a. Facility Name (If not institution, give street and number) Union Memorial Hospital				4b. City, Town, or Location of Death Baltimore		4c. County of Death n/a	
Funeral Director	5. Social Security Number 248-72-3863		6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		7. Age (In yrs. last birthday) 62 Yrs.		8. Date of Birth (Month, Day, Year) Dec. 25, 1941	
	9. Birthplace (State or Foreign Country) South Carolina		10a. State MD		10b. County n/a		10c. City, Town or Location Baltimore	
10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		10e. Street and Number 1819 Chilton St.		10f. Zip Code 21218		10g. Citizen of What Country? U.S.A.		
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: Black		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12th		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Custodian		16b. Kind of Business/Industry MD General Hospital				
17. Father's Name (First, Middle, Last) Jessie Moultrie				18. Mother's Name (First, Middle, Maiden Surname) Essie Vice				
19a. Informant's Name/Relationship (Type, Print) Barbara Moultrie/wife				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1819 Chilton St. Balto. MD 21218				
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Bethlehem Baptist Church Cemetery		20c. Location - City or Town, State Feb. 10, 2004 Alvin, S.C.				
21. Signature of Funeral Service Director 		22. Name and Address of Facility CALVIN B. SCRUGGS FUNERAL HOME 1412 E. PRESTON ST. BALTO. MD 21213						
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Anoxic Brain Injury Due to (or as a consequence of): b. lung and edema Due to (or as a consequence of): c. Due to (or as a consequence of): d. Approximate Interval Between Onset and Death 5 days 5 days								
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 4 <input type="checkbox"/> Pregnant at time of death 9 <input type="checkbox"/> Unknown		3 <input type="checkbox"/> Ectopic pregnancy 5 <input type="checkbox"/> Other (Specify)		23d. Date of delivery Month Day Year		
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input checked="" type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown		
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No						
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)						
27. Manner of Death 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		
28d. Describe how injury occurred		28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier Gani Veerakapathan		29c. License number AT2438946		29d. Date signed (Month, Day, Year) February 4th 2004		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) GOWRI VEERARACHAVAN 201, EAST UNIVERSITY PARKWAY BALTIMORE, MD 21215		31. Date filed (Month, Day, Year) FEB 09 2004		32. Registrar's Signature 				

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, a Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2004 03552

1- For
State
RegistrarPhysician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Ellwood Lincoln Manner

2. Date of Death

Month Day Year
February 5, 2004

3. Time of Death

2:20 a^MFuneral
Director

4a. Facility Name (If not institution, give street and number)

Gilchrist

4b. City, Town, or Location of Death

Towson

4c. County of Death

Baltimore

5. Social Security Number

215-10-7716

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

85 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
Feb. 12, 1918

9. Birthplace (State or Foreign Country)

Pennsylvania

Usual Residence of Decedent

10a. State

Md.

10b. County

Baltimore

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

100 Spring Towne Circle #3B

10f. Zip Code

21234

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☒ Yes 2 ☐ No

If Yes, Give

Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: White

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4or 5+)

College (1-4or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working

life. DO NOT use retired)

Steel Consultant

16b. Kind of Business/Industry

Steel

17. Father's Name (First, Middle, Last)

John Manner

18. Mother's Name (First, Middle, Maiden Sumame)

Dorothy Marie Toland

19a. Informant's Name/Relationship (Type, Print)

Mr. Gary Manner/ Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

9111 Simms Ave. Baltimore, Md. 21234

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Parkwood Cemetery

Date

2-10-04

20c. Location - City or Town, State

Parkville, Md.

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Ruck Towson Funeral Home, Inc.
1050 York Rd. Towson, Md. 21204

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Due to (or as a consequence of):

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Approximate Interval Between Onset and Death

years

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☐ No9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death4 ☐ Pregnant at time of death9 ☐ Unknown3 ☐ Ectopic pregnancy5 ☐ Other (specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☒ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier
(Check only one)

29. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

W. A. R. 107 G Bmt 6701 N. Charles St. Balts. Md 21205

31. Date filed (Month, Day, Year)

FEB 09 2004

32. Registrar's Signature

K. [Signature]

State
Registrar

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2004 03553

1- For
State
Registrar

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) MARY A. NELSON		2. Date of Death Month Day Year FEBRUARY 05 2004		3. Time of Death 10:15 A^M
	4a. Facility Name (If not institution, give street and number) MARINER HEALTH OF GLEN BURNIE		4b. City, Town, or Location of Death GLEN BURNIE		4c. County of Death ANNE ARUNDEL CO.
Funeral Director	5. Social Security Number 215-07-5628	6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 88 Yrs.	8. Date of Birth (Month, Day, Year) Dec. 29 1915	
	9. Birthplace (State or Foreign Country) Maryland		Usual Residence of Decedent		
To Be Completed by Funeral Director	10a. State Md.	10b. County Anne Arundel Co.	10c. City, Town or Location Pasadena,		10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
	10e. Street and Number 791 Woods Road		10f. Zip Code 21122		10g. Citizen of What Country? U.S.A.
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:
	14. Race - American Indian, Black, White, etc. Specify: white		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 0		
To Be Completed by Physician/Medical Examiner	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Bookkeeper		16b. Kind of Business/Industry Laurel Dodge		
	17. Father's Name (First, Middle, Last) Lawrence L. Appleby		18. Mother's Name (First, Middle, Maiden Surname) Grace I. Bosley		
	19a. Informant's Name/Relationship (Type, Print) James B. Atkin (Son)		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 791 Woods Road, Pasadena, Md. 21122		
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Druid Ridge Cemetery		20c. Location - City or Town, State Baltimore, Md.
21. Signature of Funeral Service Licensee 		22. Name and Address of Facility McCully-Polyniak Funeral Home P.A. 3204 Mountain Road, Pasadena, Md. 21122			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Metastatic Breast Cancer					
23b. Immediate Cause (Final disease or condition resulting in death) Obstructive Pnevmonia					
23c. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last HTN					
23d. Due to (or as a consequence of): atrial fibrillation					
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 9 <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) 9 <input type="checkbox"/> Unknown		23d. Date of delivery Month Day Year	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.					23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No					24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M	28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)	
29a. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.					
29b. Signature and title of certifier 		29c. License number D0054020		29d. Date signed (Month, Day, Year) February 6 2004	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 360 Hospital Drive Suite 215 Glen Burnie MD 21061					
31. Date filed (Month, Day, Year) FEB 09 2004		32. Registrar's Signature 			

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Certificate of Death

Reg. No.

2004 03554

1- For
State
Registrar

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Physician
/Medical
ExaminerFuneral
Director

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

1. Decedent's Name (First, Middle, Last) Irene Rose Orsini				2. Date of Death Month 02 Day 05 Year 2004				3. Time of Death 10:00 AM	
4a. Facility Name (If not institution, give street and number) 4045 Gilford Court				4b. City, Town, or Location of Death Jarrettsville				4c. County of Death Harford	
5. Social Security Number 214-24-1050		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 86 Yrs.		8. Date of Birth (Month, Day, Year) 04/18/1917		9. Birthplace (State or Foreign Country) Maryland	
Usual Residence of Decedent									
10a. State MD		10b. County Harford		10c. City, Town or Location Jarrettsville				10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
10e. Street and Number 4045 Gilford Court				10f. Zip Code 21084		10g. Citizen of What Country? U.S.A.			
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 7 College (1-4or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Housewife			16b. Kind of Business/Industry Homemaking		
17. Father's Name (First, Middle, Last) John McCadden						18. Mother's Name (First, Middle, Maiden Surname) Rose Marie Prietz			
19a. Informant's Name/Relationship (Type, Print) Dolores D. Mobley (daughter)				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2811 Summit Avenue - Baltimore, MD 21234					
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Highview Mem. Gdns.		Date 02/09/2004		20c. Location - City or Town, State Fallston, Maryland	
21. Signature of Funeral Service Licensee E. F. Lassahn				22. Name and Address of Facility E. F. Lassahn Funeral Home, P.A. 11750 Belair Road - Kingsville, MD 21087					
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. longestive heart failure Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Approximate Interval Between Onset and Death years									
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Arteriosclerosis Diabetes									
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown				23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Other (specify)				23d. Date of delivery Month Day Year	
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide				28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
28d. Describe how injury occurred				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)					
28f. Location (Street and Number or Rural Route Number, City or Town, State)				28g. Describe how injury occurred					
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.									
29b. Signature and title of certifier Mark Lamus MD				29c. License number D34521		29d. Date signed (Month, Day, Year) 02/05/04			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 9 Schilling Rd. Su. 1 Hunt Valley, MD 21031									
31. Date filed (Month, Day, Year) FEB 09 2004				32. Registrar's Signature [Signature]					

State
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2004 03555

1- For
State
RegistrarPhysician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

ANNA M. OSWINKLE

2. Date of Death

Month

Day

Year

2 2 2004 5:57 PM

3. Time of Death

Funeral
Director

4a. Facility Name (If not institution, give street and number)

FRANKLIN SQUARE Hospital

4b. City, Town, or Location of Death

Rose Dale

4c. County of Death

BALTIMORE

5. Social Security Number

219-05-5552

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

84 Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

JAN. 18, 1920

9. Birthplace (State or Foreign Country)

MD.

Usual Residence of Decedent

10a. State

MD.

10b. County

N/A

10c. City, Town or Location

BALTIMORE

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

1104 BROENING HIGHWAY

10f. Zip Code

21224

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

1 ☐ Yes 2 ☒ No
If Yes, Give
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: WHITE

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

12TH

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

HOMEMAKER

16b. Kind of Business/Industry

OWN HOME

17. Father's Name (First, Middle, Last)

MILTON ANDREW WIENECKE

18. Mother's Name (First, Middle, Maiden Surname)

JOHANNA BLUME

19a. Informant's Name/Relationship (Type, Print)

DONALD J. OSWINKLE/SON

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

8 SILVERWOOD COURT, BALTIMORE, MARYLAND 21236

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

OAK LAWN CEMETERY

Date

2/6/04

20c. Location - City or Town, State

BALTIMORE, MARYLAND

21. Signature of Funeral Service Licensee

[Signature]

22. Name and Address of Facility

CHARLES S. ZEILER & SON, INC.

6224 EASTERN AVE., BALTIMORE, MARYLAND 21224

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

a. Severe Sepsis

Due to (or as a consequence of):

Approximate
Interval Between
Onset and Death

5 DAYS

Sequentially list conditions,
if any, leading to immediate
cause. Enter underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

b. Pneumonia

Due to (or as a consequence of):

6 DAYS

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

IF FEMALE:

23b. Was decedent pregnant
in the past 12 months?1 ☐ Yes 2 ☒ No
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy
4 ☐ Pregnant at time of death 5 ☐ Other (specify)
9 ☐ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Acute MI

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an
autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings available
prior to completion of cause of
death?1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation
6 ☐ Could not be determined28a. Date of Injury
(Month, Day, Year)28b. Time of
Injury

M

28c. Injury at
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
and manner stated.

29b. Signature and title of certifier

[Signature]

29c. License number

D28 717

29d. Date signed (Month, Day, Year)

2-2-2004

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DR STEPHEN SELINGER 9000 FRANKLIN SQUARE DR. BALTIMORE MD 21237

31. Date filed (Month, Day, Year)

FEB 09 2004

32. Registrar's Signature

[Signature]

State
Registrar

ORIGINAL

Baltimore, Maryland 21215-0036
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28e-f show
any injury or other traumatic event, the Medical Examiner must be notified at
once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit
certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2004 03556

1- For State Registrar

Physician / Medical Examiner	1. Decedent's Name (First, Middle, Last) PROEUNG PHUNG		2. Date of Death Month: Feb Day: 1 Year: 2004		3. Time of Death 0610 M
	4a. Facility Name (If not institution, give street and number) Laurel Regional Hospital		4b. City, Town, or Location of Death Laurel		4c. County of Death Prince George
Funeral Director	5. Social Security Number 579-04-8837	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 87 Yrs.	8. Date of Birth (Month, Day, Year) July 7, 1916	
	9. Birthplace (State or Foreign Country) Cambodia		10a. State MD		
To Be Completed by Funeral Director	10b. County Montgomery		10c. City, Town or Location Silver Spring		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
	10e. Street and Number 12301 Blakely Court,		10f. Zip Code 20904		10g. Citizen of What Country? USA
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:
	14. Race - American Indian, Black, White, etc. Specify: Asian		15. Decedent's Education (Specify only highest grade completed) 12 Elementary/Secondary (0-12) 4+ College (1-4 or 5+)		
	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Architectural Artist		16b. Kind of Business/Industry Independent		
	17. Father's Name (First, Middle, Last) (Unavailable)		18. Mother's Name (First, Middle, Maiden Surname) (Unavailable)		
	19a. Informant's Name/Relationship (Type, Print) Kan Phung / Son		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12301 Blakely Court, Silver Spring, Maryland 20904		
	20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Balt/Wash Crematory		20c. Location - City or Town, State Laurel, Maryland
	21. Signature of Funeral Service Licensee Kenya Stewart M0138		22. Name and Address of Facility Fleck Funeral Home, Inc. 7601 Sandy Spring Road, Laurel, Maryland 20707		
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Aspiration pneumonia Approximate Interval Between Onset and Death Days				
23b. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. - Severe anemia - hypertension - prostatism					
23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <input type="checkbox"/> Unknown					
23d. Date of delivery Month Day Year					
23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown					
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined					
28a. Date of Injury (Month, Day, Year)					
28b. Time of Injury M					
28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
28d. Describe how injury occurred					
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)					
28f. Location (Street and Number or Rural Route Number, City or Town, State)					
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.					
29b. Signature and title of certifier Prilana					
29c. License number P28998					
29d. Date signed (Month, Day, Year) 2-1-04					
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) PRITAM S SAINI MD 9101 Cherry Lane Suite 211 Laurel MD 20708					
31. Date filed (Month, Day, Year) FEB 09 2004					
32. Registrar's Signature [Signature]					

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

State Registrar

ORIGINAL

Randolph Price
04-00896
MAN

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For Unpend Items 23a, 27, 28a-f per ME, G828, 02/13/04
Certificate of Death

Reg. No.

2004 03557

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Randolph W. Price

2. Date of Death

February 02, 2004

3. Time of Death

1740 P M

Funeral
Director

4a. Facility Name (If not institution, give street and number)

2501 Boston Strret Pier D

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

5. Social Security Number

220-48-3423

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

55 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

10-30-1948

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

MD

10b. County

n/a

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

2501 Boston Street

10f. Zip Code

21224

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☒ Yes 2 ☐ No
If Yes, Give Year or Dates: 1966-68

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: white

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)
12th

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Carpenter

16b. Kind of Business/Industry

construction

17. Father's Name (First, Middle, Last)

Ross W. Price

18. Mother's Name (First, Middle, Maiden Surname)

Marvel R. Sample

19a. Informant's Name/Relationship (Type, Print) sister

Bobbi G. Smick

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

225 Osprey Ct. Vero Beach, Florida 32963

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Greenmount

Date

2/7/2004

20c. Location - City or Town, State

Baltimore, MD

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Joseph N. Zannino Jr. FH

263 S. Conkling St. Baltimore, MD 21224

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or head failure. List only one cause on each line.

Drowning complicating acute alcohol intoxication

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown

3 ☐ Ectopic pregnancy

5 ☐ Other (specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☒ Yes 2 ☐ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☒ Yes 2 ☐ No

25. Was case referred to medical examiner?
☒ Yes 2 ☐ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☒ Other (Specify) At scene

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury

Found 2/2/04

28b. Time of Injury

Found 5:30 PM

28c. Injury at Work?

1 ☐ Yes 2 ☒ No

28d. Describe how injury occurred

subject drowned

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
found in water

28f. Location (Street and Number or Rural Route Number, City or Town, State)
2501 Boston Street, Pier D
Baltimore, MD

29a. Certifier (Check only one)

1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated.
2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Tasha Z Greenberg MD

29c. License number

O.C.M.E.

29d. Date signed (Month, Day, Year)

February 03, 2004

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Tasha Z Greenberg M.D. 111 Penn Street, Baltimore, Maryland 21201

31. Date filed (Month, Day, Year)

FEB 09 2004

32. Registrar's Signature

[Signature]

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- Amend Item 28a per Dr. G828, 02/09/04 ddb

Certificate of Death

Reg. No.

2004 03558

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <u>Kay Potter</u>		2. Date of Death Month <u>January</u> Day <u>16</u> Year <u>2004</u>		3. Time of Death <u>15:30</u> M
	4a. Facility Name (If not institution, give street and number) <u>Johns Hopkins Hospital</u>		4b. City, Town, or Location of Death <u>Baltimore</u>		4c. County of Death <u>n/a</u>
Funeral Director	5. Social Security Number <u>219-58-5927</u>	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <u>51</u> Yrs.	8. Date of Birth (Month, Day, Year) <u>Oct. 19, 1952</u>	9. Birthplace (State or Foreign Country) <u>Maryland</u>
	Usual Residence of Decedent				
To Be Completed by Funeral Director	10a. State <u>MD</u>	10b. County <u>Harford</u>	10c. City, Town or Location <u>White Hall</u>		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
	10e. Street and Number <u>4706 Norrisville Road</u>		10f. Zip Code <u>21161</u>		10g. Citizen of What Country? <u>United States</u>
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <u>2</u> College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <u>Registered Nurse</u>		16b. Kind of Business/Industry <u>Health Care</u>
	17. Father's Name (First, Middle, Last) <u>Charles Potter, Sr.</u>		18. Mother's Name (First, Middle, Maiden Surname) <u>Catherine Felling</u>		
	19a. Informant's Name/Relationship (Type, Print) <u>Charles Potter, Jr./brother</u>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>5775 S. Kline Street #129 Littleton, CO 80127</u>		
	20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <u>Hilltop Svc. Corp.</u>		20c. Location - City or Town, State <u>Towson, Maryland</u>
	21. Signature of Funeral Service Licensee <u>[Signature]</u>		22. Name and Address of Facility <u>Ruck Towson Funeral Home, Inc. 1050 York Road Towson, Maryland 21204</u>		
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <u>Subarachnoid Hemorrhage</u>				
	23b. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <u>Subarachnoid Hemorrhage</u>		23b. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		Approximate Interval Between Onset and Death <u>18 hours</u>
	23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Unknown		23d. Date of delivery Month <u> </u> Day <u> </u> Year <u> </u>		
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year) <u>January 12, 2004</u>		28b. Time of Injury <u> </u> M
	28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred		
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)		
	29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				
	29b. Signature and title of certifier <u>Jay R. Levin, MD</u>		29c. License number <u>Res-000</u>		29d. Date signed (Month, Day, Year) <u>January 18, 2004</u>
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <u>Jay Levin 915 Kenwood Avenue Baltimore, MD 21224</u>				
	31. Date filed (Month, Day, Year) <u>FEB 09 2004</u>		32. Registrar's Signature <u>[Signature]</u>		

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

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State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar AMEND ITEM #19b PER FH G828 2/10/04 Certificate of Death

Reg. No. 2004 03559

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Norris James Reid			2. Date of Death Month February Day 4 Year 2004		3. Time of Death 130 p M	
	4a. Facility Name (If not institution, give street and number) Maryland General Hospital Baltimore			4b. City, Town, or Location of Death Baltimore		4c. County of Death N/A	
Funeral Director	5. Social Security Number 237-05-4626		6. Sex 1 M 2 F	7. Age (In yrs. last birthday) 91 Yrs.		8. Date of Birth (Month, Day, Year) March 23, 1912	
	9. Birthplace (State or Foreign Country) NC						
To Be Completed by Funeral Director	Usual Residence of Decedent						
	10a. State MD	10b. County N/A	10c. City, Town or Location Baltimore			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
	10e. Street and Number 2605 Mt. Holly Street		10f. Zip Code 21216		10g. Citizen of What Country? U.S.A.		
	11. Marital Status 2 Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 2 No <input type="checkbox"/> Yes <input type="checkbox"/> No		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 2 No Specify:		14. Race - American Indian, Black, White, etc. Specify: Black
	15. Decedent's Education (Specify only highest grade completed) 12th		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Steel Worker		16b. Kind of Business/Industry Bethelhem Steel		
	17. Father's Name (First, Middle, Last) ukn			18. Mother's Name (First, Middle, Maiden Surname) ukn			
	19a. Informant's Name/Relationship (Type, Print) Kirk Smith - Grandson			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3509 N. Childress St. Flagstaff, AZ 86004			
	20a. Method of Disposition 1 Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Mt. Zion Cemetery		20c. Location - City or Town, State 2/10/04 Landsdowne, MD		
	21. Signature of Funeral Service Licensee 		22. Name and Address of Facility Nutter Funeral Homes, Inc. 2501 Gwynns Falls Pkwy. Baltimore, MD 21216				
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. a. Arteriosclerotic Cardiovascular Disease Due to (or as a consequence of): b. Dehydration Due to (or as a consequence of): c. Atrial Fibrillation Due to (or as a consequence of): d.						
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <input type="checkbox"/> Unknown			23d. Date of delivery Month Day Year		
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Hypertension Congestive Heart Failure					23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No					
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28d. Describe how injury occurred					
28f. Location (Street and Number or Rural Route Number, City or Town, State)							
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.							
29b. Signature and title of certifier 		29c. License number 89494		29d. Date signed (Month, Day, Year) 2/4/04			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Mansoor Lateef, MD c/o Maryland General Hospital							
31. Date filed (Month, Day, Year) FEB 09 2004		32. Registrar's Signature 					

Red, Norris
Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2004 03560

1- For
State
Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Frances Anita Rogers			2. Date of Death Month Day Year February 2, 2004		3. Time of Death 2:45 A M	
	4a. Facility Name (If not institution, give street and number) 309 Derek Street			4b. City, Town, or Location of Death Upper Marlboro		4c. County of Death Prince George's	
Funeral Director	5. Social Security Number 577-30-2087		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 79 Yrs.		8. Date of Birth (Month, Day, Year) 11/18/1924
	9. Birthplace (State or Foreign Country) Pennsylvania		10a. State Maryland		10b. County Prince George's		10c. City, Town or Location Forestville
To Be Completed by Funeral Director	10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		10e. Street and Number 2615 Timbercrest Drive		10f. Zip Code 20747		10g. Citizen of What Country? USA
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: Black
To Be Completed by Physician/Medical Examiner	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Registered Nurse		16b. Kind of Business/Industry Medical		
	17. Father's Name (First, Middle, Last) Thomas Francis Nelson		18. Mother's Name (First, Middle, Maiden Surname) Mary Ann Marshall				
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) Eileen Rogers / Daughter			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2615 Timbercrest Dr. Forestville, Maryland 20747			
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Resurrection Cem.		20c. Location - City or Town, State Clinton, Maryland		20d. Date 02/09/2004
To Be Completed by Physician/Medical Examiner	21. Signature of Funeral Service Licensee [Signature]		22. Name and Address of Facility George P. Kalas Funeral Home P.A. 6160 Oxon Hill Road Oxon Hill, Maryland 20745				
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) HYPERTENSIVE CARDIOMYOPATHY a. Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Approximate Interval Between Onset and Death 10 years						
To Be Completed by Physician/Medical Examiner	23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 9 <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) 9 <input type="checkbox"/> Unknown		23d. Date of delivery Month Day Year		
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown		
To Be Completed by Physician/Medical Examiner	24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No				
	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other (Specify) Son's Residence		27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		
To Be Completed by Physician/Medical Examiner	28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)				
To Be Completed by Physician/Medical Examiner	29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.						
	29b. Signature and title of certifier [Signature]		29c. License number D28195		29d. Date signed (Month, Day, Year) 02/02/2004		
To Be Completed by Physician/Medical Examiner	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) David Gooray MD 1450 Mercantile Lane #217 Largo, Maryland 20774						
	31. Date filed (Month, Day, Year) FEB 09 2004		32. Registrar's Signature [Signature]				

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2004 03561

1- For
State
RegistrarPhysician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Evelyn Anna Sullivan Roberts

2. Date of Death

Month Day Year
Feb. 03 2004

3. Time of Death

7:59pm^MFuneral
Director

4a. Facility Name (If not institution, give street and number)

322 North Lapidum Rd.

4b. City, Town, or Location of Death

Havre de Grace

4c. County of Death

Harford

5. Social Security Number

067-20-2379

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

76

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
03/11/1927

9. Birthplace (State or Foreign Country)

New York

Usual Residence of Decedent

10a. State

MD

10b. County

Harford

10c. City, Town or Location

Havre de Grace

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

322 North Lapidum Rd.

10f. Zip Code

21078

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: White

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

6 years

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Teacher

16b. Kind of Business/Industry

Elementary School

17. Father's Name (First, Middle, Last)

Bert Sullivan

18. Mother's Name (First, Middle, Maiden Surname)

Marie Leonard

19a. Informant's Name/Relationship (Type, Print)

Boyce M. Roberts- Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

322 N. Lapidum Rd., Havre de Grace, MD 21078

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

R.A. Ferris & Co.

Date

02/05/04

20c. Location - City or Town, State

West Chester, PA

21. Signature of Funeral Service Licensee

Arlene M. Smith

22. Name and Address of Facility

Mitchell-Smith Funeral Home, P.A.
123 S. Washington, Havre de Grace, MD 2107823a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

Congestive Heart Failure

Approximate
Interval Between
Onset and Death

a. Due to (or as a consequence of):

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

IF FEMALE:

23b. Was decedent pregnant
in the past 12 months?
1 ☐ Yes 2 ☒ No
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 5 ☐ Other (specify)
9 ☐ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Colon Cancer

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an
autopsy
performed?
1 ☐ Yes 2 ☒ No24b. Were autopsy findings available
prior to completion of cause of
death?
1 ☐ Yes 2 ☒ No25. Was case referred to medical
examiner?
1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DCA Other: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending
investigation
2 ☐ Accident 6 ☐ Could not be
determined
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury

(Month, Day Year)

28b. Time of
Injury28c. Injury at
Work?1 ☐ Yes 2 ☒ No28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Leech MD

29c. License number

D0058904

29d. Date signed (Month, Day, Year)

2/4/2004

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

319 S Union Avenue Havre de Grace MD 21078

31. Date filed (Month, Day, Year)

FEB 09 2004

32. Registrar's Signature

[Signature]

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2004 03562

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Robert Reed

2. Date of Death

02 06 2004

3. Time of Death

3:05am

4a. Facility Name (If not institution, give street and number)

River View Nursing Home

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

Baltimore

Funeral
Director

5. Social Security Number

236-32-3718

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

76

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

04-19-1927

9. Birthplace (State or Foreign Country)

West Virginia

Usual Residence of Decedent

10a. State

MD

10b. County

Baltimore

10c. City, Town or Location

Forest Hill

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

500 Kilarney Court

10f. Zip Code

21015

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☒ Never Married 2 ☐ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☒ Yes 2 ☐ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

1

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Bartender

16b. Kind of Business/Industry

The Monicle Restaurant

17. Father's Name (First, Middle, Last)

John T. Reed

18. Mother's Name (First, Middle, Maiden Surname)

Ida Bessie Eller

19a. Informant's Name/Relationship (Type, Print)

Sandra S. Herlihy, Niece

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

500 Kilarney Court, Forest Hill, Maryland 21015

20a. Method of Disposition

1 ☐ Burial 2 ☐ Cremation 3 ☒ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Burke Memorial Park

Date

2/10/2004

20c. Location - City or Town, State

Morganton, NC

21. Signature of Funeral Service Licensee

► [Signature] MO1350

22. Name and Address of Facility

Fleck Funeral Home, Inc.

7601 Sandy Spring Rd, Laurel, Maryland 20707

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Arteriosclerotic Coronary Vascular Disease

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

years.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Chronic Obstructive Pulmonary Disease

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury

(Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

► [Signature]

29c. License number

D18667

29d. Date signed (Month, Day, Year)

02-07-2004

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Malika Wasseem, M.D. 709 Eastern Blvd. Baltimore, MD 21221

31. Date filed (Month, Day, Year)

FEB 09 2004

32. Registrar's Signature

► [Signature]

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23e or 28e-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2004 03563

1- For
State
Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Eugene Charles Reisig				2. Date of Death Month Day Year January 31, 2004		3. Time of Death 6:35 P M			
	4a. Facility Name (If not institution, give street and number) Upper Chesapeake Medical Center			4b. City, Town, or Location of Death Bel Air		4c. County of Death Harford				
Funeral Director	5. Social Security Number 218-22-2397		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) Yrs. WW II	8. Date of Birth (Month, Day, Year) 09/26/1927		9. Birthplace (State or Foreign Country) Maryland			
	Usual Residence of Decedent				10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
To Be Completed by Funeral Director	10a. State MD		10b. County Harford		10c. City, Town or Location Bel Air		10d. Inside City Limits			
	10e. Street and Number 202 Thames Way				10f. Zip Code 21014		10g. Citizen of What Country? U.S.A.			
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: WW II		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White			
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 10 College (1-4 or 5+) College		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Assembly Person		16b. Kind of Business/Industry American Can Co.					
	17. Father's Name (First, Middle, Last) John Reisig				18. Mother's Name (First, Middle, Maiden Surname) Carrie Schutte					
	19a. Informant's Name/Relationship (Type, Print) Dorothy Sue Kimmel (Dtr.in-law)				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1373 Harford Square Drive - Edgewood, MD 21040					
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Highview Memorial Gd.		20c. Location - City or Town, State 02/07/2004 Fallston, Maryland		20d. Date			
	21. Signature of Funeral Service Licensee E. F. Lassahn		22. Name and Address of Facility E. F. Lassahn Funeral Home, P.A. 11750 Belair Road - Kingsville, MD 21087							
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Atherosclerotic Cardiovascular disease Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last								Approximate Interval Between Onset and Death	
	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown 23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Other (specify) <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Unknown 23d. Date of delivery Month Day Year									
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown 24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No 24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No										
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)								
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred		
29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier E. F. Lassahn M.D.		29c. License number O.C.M.E.		29d. Date signed (Month, Day, Year) February 01, 2004				
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) LING LI, M.D. 111 Penn Street, Baltimore, Maryland 21201										
31. Date filed (Month, Day, Year) FEB 09 2004		32. Registrar's Signature [Signature]								

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2004 03564

1- For
State
RegistrarPhysician
/Medical
ExaminerFuneral
Director

1. Decedent's Name (First, Middle, Last) Roy Daniel Redding				2. Date of Death Month Feb. 7, Day 2004 Year		3. Time of Death 1:30 a M	
4a. Facility Name (If not institution, give street and number) Carroll Hospital Center				4b. City, Town, or Location of Death Westminster		4c. County of Death Carroll	
5. Social Security Number 213-16-1904		6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		7. Age (In yrs. last birthday) 82 Yrs.		8. Date of Birth (Month, Day, Year) Aug. 9, 1921	
9. Birthplace (State or Foreign Country) Manchester							
Usual Residence of Decedent							
10a. State Md.		10b. County Carroll		10c. City, Town or Location Westminster		10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
10e. Street and Number 39 Kate Wagner Ct.				10f. Zip Code 21157		10g. Citizen of What Country? U.S.A.	
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No WW II If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Mason		16b. Kind of Business/Industry Brick Construction	
17. Father's Name (First, Middle, Last) Aaron I. Redding				18. Mother's Name (First, Middle, Maiden Surname) Florence E. Kerchner			
19a. Informant's Name/Relationship (Type, Print) Kathy Baker - Daughter				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 39 Kate Wagner Ct., Westminster, Md. 21157			
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Miller's Ch. Cemetery		Date Feb. 10, 2004		20c. Location - City or Town, State Millers, Md.	
21. Signature of Funeral Service Licensee H. J. Schmitt				22. Name and Address of Facility Eckhardt Funeral Chapel, P.A. 296 Charmil Dr., Manchester, Md. 21102			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Acute myocardial infarction Due to (or as a consequence of): b. ASCVD Due to (or as a consequence of): c. Advanced age Due to (or as a consequence of): d. Approximate Interval Between Onset and Death 48 hrs 25 yrs 81 yrs							
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) 9 <input type="checkbox"/> Unknown				23d. Date of delivery Month Day Year	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown	
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
28d. Describe how injury occurred				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			
28f. Location (Street and Number or Rural Route Number, City or Town, State)							
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.							
29b. Signature and title of certifier John W. Middleton MD				29c. License number D 25443		29d. Date signed (Month, Day, Year) 2/7/2004	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) John W. Middleton 688 Kate Road, Westminster, MD 21157							
31. Date filed (Month, Day, Year) FEB 09 2004				32. Registrar's Signature B. Sparks			

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

State
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2004 03565

1- For
State
RegistrarPhysician
/Medical
ExaminerFuneral
Director

1. Decedent's Name (First, Middle, Last)

HELEN M. ROCKWELL

2. Date of Death

Month Day Year
FEBRUARY 5, 2004

3. Time of Death

3:25 P. M

4a. Facility Name (If not institution, give street and number)

1818 CEDAR DRIVE

4b. City, Town, or Location of Death

SEVERN

4c. County of Death

ANNE ARUNDEL

5. Social Security Number

215-28-4249

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

72 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth (Month, Day, Year)

APRIL 29, 1931

9. Birthplace (State or Foreign Country)

VIRGINIA

Usual Residence of Decedent

10a. State
MARYLAND10b. County
ANNE ARUNDEL

10c. City, Town or Location

SEVERN

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

1818 CEDAR DRIVE

10f. Zip Code

21144

10g. Citizen of What Country?

UNITED STATES

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)
10

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

HOMEMAKER

16b. Kind of Business/Industry

OWN HOME

17. Father's Name (First, Middle, Last)

LEONARD L. FRIES

18. Mother's Name (First, Middle, Maiden Surname)

EULA BAUGHER

19a. Informant's Name/Relationship (Type, Print)

WILLIAM T. ROCKWELL, SR./HUSBAND

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1818 CEDAR DRIVE SEVERN, MD 21144

20a. Method of Disposition

1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

CROWNSVILLE MD. VET. CEM.

Date

FEB. 9, 2004

20c. Location - City or Town, State

CROWNSVILLE, MD

21. Signature of Funeral Service Licensee

KIRKLEY RODDICK

KIRKLEY RODDICK FUNERAL HOME P.A.

421 CRAIN HWY. S.E. GLEN BURNIE, MD 21061

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Lung Cancer Small cell

Approximate Interval Between Onset and Death

7 months

Due to (or as a consequence of):

Liver metastasis

7 months

Due to (or as a consequence of):

Brain metastasis

1 month

Due to (or as a consequence of):

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☒ No
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown3 ☐ Ectopic pregnancy
5 ☐ Other (specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death Check on one

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation
2 ☐ Accident 6 ☐ Could not be determined
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Gayatri Nimmagadda

29c. License number

D39041

29d. Date signed (Month, Day, Year)

February 6th 2004

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

GAYATRI NIMMAGADDA 305 Hospital Drive Glen Burnie 21061

31. Date filed (Month, Day, Year)

FEB 09 2004

32. Registrar's Signature

[Signature]

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

State
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2004 03566

1- For
State
RegistrarPhysician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

SARA

RICE

2. Date of Death

FEB.

2

Day

2004

Year

3. Time of Death

7:25 P M

Funeral
Director

4a. Facility Name (If not institution, give street and number)

7121 PARK HEIGHTS AVENUE #907

4b. City, Town, or Location of Death

BALTIMORE

4c. County of Death

N/A

5. Social Security Number

312-22-3217

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

91

Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

MAR. 26, 1912

(Month, Day, Year)

9. Birthplace (State or Foreign Country)

MD

Usual Residence of Decedent

10a. State

MD

10b. County

N/A

10c. City, Town or Location

BALTIMORE

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

7121 PARK HEIGHTS AVENUE #907

10f. Zip Code

21215

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

5+

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

NURSE

16b. Kind of Business/Industry

MEDICINE

17. Father's Name (First, Middle, Last)

MAYER

18. Mother's Name (First, Middle, Maiden Surname)

SIGEL

REBECCA

(UNKNOWN)

19a. Informant's Name/Relationship (Type, Print)

BENSON RICE / SON

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

5702 COLEY COURT - BALTIMORE, MD 21210

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

BETH JACOB CEMETERY

Date

2/5/2004

20c. Location - City or Town, State

FINKSBURG, MD

21. Signature of Funeral Service Licensee

Edward C. Rind

22. Name and Address of Facility

SOL LEVINSON & BROS. INC.

8900 REISTERSTOWN ROAD PIKESVILLE, MD. 21208

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. pneumonia

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death
(week)

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☒ No3 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death3 ☐ Ectopic pregnancy4 ☐ Pregnant at time of death5 ☐ Other (specify)9 ☐ Unknown

23d. Date of delivery

Month

Day

Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Severe dementia - Alzheimer's type

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Julie H.

29c. License number

027123

29d. Date signed (Month, Day, Year)

2/3/04

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Julie Hinkov 750 Main St. Reisterstown. MD 21230

31. Date filed (Month, Day, Year)

FEB 9 2004

32. Registrar's Signature

John A. Hinkov

State
Registrar

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 410-528-9058.

Physician
/Medical
ExaminerTo the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2004 03567

1- For
State
RegistrarPhysician
/Medical
ExaminerFuneral
Director

1. Decedent's Name (First, Middle, Last)

Joseph Stanley Sufczinski

2. Date of Death

February 4, 2004

3. Time of Death

5:00 A.^M

4a. Facility Name (If not institution, give street and number)

Continuum Care Sykesville

4b. City, Town, or Location of Death

Sykesville

4c. County of Death

Carroll

5. Social Security Number

214-14-2744

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

79

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth (Month, Day, Year)

March 6, 1924

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State
Maryland10b. County
Carroll10c. City, Town or Location
Sykesville

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

7309 Second Ave.

10f. Zip Code

21784

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☒ Never Married 2 ☐ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☒ Yes 2 ☐ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

8th

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Welder

16b. Kind of Business/Industry

Wrought Iron

17. Father's Name (First, Middle, Last)

Frank Sufczinski

18. Mother's Name (First, Middle, Maiden Surname)

Sophia Helinski

19a. Informant's Name/Relationship (Type, Print)

Sharon Beck / Niece

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

6707 Sweet Clover Ct., Eldersburg, Md. 21784

20a. Method of Disposition

1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

St. Stanislaus Cemt.

Date

2-7-04

20c. Location - City or Town, State

Balto., Md. 21224

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Bradley Ashton Matthews Funeral Home, Inc.,
2134 Willow Spring Rd., Balto., Md. 21222

23. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate
Interval Between
Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Respiratory Failure
Due to (or as a consequence of):b. Alzheimer's Disease
Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☐ No
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy
4 ☐ Pregnant at time of death 5 ☐ Other (specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Mild congestive heart failure

23e. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician2 ☐ Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Michael R. Keough, M.D.

29c. License number

014753

29d. Date signed (Month, Day, Year)

2/10/04

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

4000 Old Kent Road, Michael J. Porter

31. Date filed (Month, Day, Year)

FEB 09 2004

32. Registrar's Signature

[Signature]

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural," or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For
State
Registrar

AMEND ITEM#8 PER FH G828 2/12/04 JH Certificate of Death

Reg. No.

2004 03568

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Robert L. Stiles, SR.

2. Date of Death

2 5 2004

3. Time of Death

5:47 P M

Funeral
Director

4a. Facility Name (If not institution, give street and number)

FRANKLIN SQUARE Hospital

4b. City, Town, or Location of Death

Rosedale

4c. County of Death

BALTIMORE

5. Social Security Number

220-12-7954

6. Sex

1 M 2 F

7. Age (In yrs. last birthday)

74 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth (Month, Day, Year)

6-29-27

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

MD

10b. County

HARFORD

10c. City, Town or Location

Forest Hill

10d. Inside City Limits

1 Yes 2 No

10e. Street and Number

1 Colgate Drive

10f. Zip Code

21050

10g. Citizen of What Country?

USA

11. Marital Status

1 Never Married 2 Married
3 Widowed 4 Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 Yes 2 No Specify:

14. Race - American Indian, Black, White, etc.

Specify: white.

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4or 5+)

12

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Machinist

16b. Kind of Business/Industry

Bethlehem Steel

17. Father's Name (First, Middle, Last)

J. Newton Stiles

18. Mother's Name (First, Middle, Maiden Surname)

Ruth Wilbur

19a. Informant's Name/Relationship (Type, Print)

Virginia L. Stiles

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1 Colgate Dr., Forest Hill, MD 21050

20a. Method of Disposition

1 Burial 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Meadowridge Cem. Park

Date

2-10-04

20c. Location - City or Town, State

Ft. Ridge, MD

21. Signature of Funeral Service Licensee

Kimberly D. Zuckerman

22. Name and Address of Facility

3 NEWPORT DR., FOREST HILL, MD
EVANS FUNERAL CHAPEL - BEL AIR, P.A. 21050

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Sepsis

Due to (or as a consequence of):

b. METASTATIC CANCER OF UNKNOWN ORIGIN

Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No
9 Unknown

23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death 3 Ectopic pregnancy
4 Pregnant at time of death 5 Other (Specify)
9 Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Coagulopathy, Atrial Fibrillation
DM

23e. Did tobacco use contribute to the cause of death?

1 Yes 2 No 3 Probably 4 Unknown

24a. Was an autopsy performed?

1 Yes 2 No

24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No

25. Was case referred to medical examiner?

1 Yes 2 No

Hospital:

1 Inpatient 2 Outpatient 3 DOA

Other:

4 Nursing Home 5 Residence 6 Other (Specify)

27. Manner of Death

1 Natural 2 Accident 3 Suicide 4 Homicide
5 Pending investigation 6 Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 Yes 2 No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Dr. Jack Ko

29c. License number

D55885

29d. Date signed (Month, Day, Year)

2/5/04

30. Name and address person who completed cause of death (Item 23a) (Type, Print)

DR JACK KO 9000 FRANKLIN SQUARE DR. BALTIMORE MD 21237

31. Date filed (Month, Day, Year)

FEB 09 2004

32. Registrar's Signature

K. A. Sparks

State
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2004 03569

1- For State Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) LOUISE SIMMONS			2. Date of Death Month February Day 8 Year 2004		3. Time of Death 10:00 AM	
	4a. Facility Name (If not institution, give street and number) Maryland General Hospital			4b. City, Town, or Location of Death Baltimore City		4c. County of Death N/A	
Funeral Director	5. Social Security Number 247-17-3202		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 80 Yrs.		8. Date of Birth (Month, Day, Year) JAN. 7, 1924
	9. Birthplace (State or Foreign Country) SC						
Usual Residence of Decedent							
10a. State MD		10b. County N/A		10c. City, Town or Location BALTIMORE		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
10e. Street and Number 1517 LESLIE STREET				10f. Zip Code 21217		10g. Citizen of What Country? USA	
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: BLACK	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 10 College (1-4 or 5+) DOMESTIC				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) HOUSEWORK		16b. Kind of Business/Industry	
17. Father's Name (First, Middle, Last) HOLLIE PROCTOR				18. Mother's Name (First, Middle, Maiden Surname) MARY MARION			
19a. Informant's Name/Relationship (Type, Print) PATRICIA SIMMONS KEELS/DAUGHTER				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1517 LESLIE ST., BALTIMORE, MD 21217			
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) ARBUTUS		Date 02/12/2004		20c. Location - City or Town, State BALTIMORE, MD	
21. Signature of Funeral Service Licensee <i>James A. Morton</i>		22. Name and Address of Facility JAMES A. MORTON & SONS F.H., INC 1701 LAURENS ST., BALTO., MD 21217					
23a. (Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.) Immediate Cause (Final disease or condition resulting in death) anoxic Encephalopathy							
a. Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d.							
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown 23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <input type="checkbox"/> Unknown							
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23d. Date of delivery Month Day Year	
						23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown	
						24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
						24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA		26. Place of Death (Check only one) Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
		28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			
		28f. Location (Street and Number or Rural Route Number, City or Town, State)					
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.							
29b. Signature and title of certifier <i>Wazir (House Staff)</i>				29c. License number P89506		29d. Date signed (Month, Day, Year) February 8, 2004	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Wazir, Shahid MD, C/o Maryland General Hospital							
31. Date filed (Month, Day, Year) FEB - 9 2004				32. Registrar's Signature <i>[Signature]</i>			

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

Baltimore, Maryland 21215-0036

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2004 03570

1- For
State
RegistrarPhysician
/Medical
ExaminerFuneral
Director

To Be Completed by Funeral Director

1. Decedent's Name (First, Middle, Last) EVA ELIZABETH SHANKLIN				2. Date of Death Month FEBRUARY Day 8 Year 2004		3. Time of Death 12:40 A.^M	
4a. Facility Name (If not institution, give street and number) MARINER HEALTH OF FOREST HILL				4b. City, Town, or Location of Death FOREST HILL		4c. County of Death HARFORD	
5. Social Security Number 214-07-4308		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 89 Yrs.		8. Date of Birth (Month, Day, Year) April 9, 1914	
9. Birthplace (State or Foreign Country) Maryland		Usual Residence of Decedent					
10a. State Maryland		10b. County Baltimore		10c. City, Town or Location Essex		10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
10e. Street and Number 517 Riverside Drive				10f. Zip Code 21221		10g. Citizen of What Country? U. S. A.	
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 6 College (1-4 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker		16b. Kind of Business/Industry Own Home	
17. Father's Name (First, Middle, Last) Michael Long				18. Mother's Name (First, Middle, Maiden Surname) Nellie Pearl Brotemarkle			
19a. Informant's Name/Relationship (Type, Print) Jacquelin Barnes (Daughter)				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2720 Merrick Way Abingdon, Maryland 21009			
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Belair Memorial Gardens		Date 2/11 2004		20c. Location - City or Town, State Harford, Maryland	
21. Signature of Funeral Service Licensee <i>Michael C. Jaffard Sr.</i>				22. Name and Address of Facility Bruzdzinski Funeral Home PA 1407 Old Eastern Avenue Essex, Maryland 21221			

Physician
/Medical
Examiner

To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Metastatic Brain Tumors Due to (or as a consequence of): b. Non Small Cell Carcinoma of Lung Due to (or as a consequence of): c. Due to (or as a consequence of): d. Approximate Interval Between Onset and Death one year			
23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 9 <input type="checkbox"/> Unknown			
23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) 9 <input type="checkbox"/> Unknown			
23d. Date of delivery Month Day Year			
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.			
23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input checked="" type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown			
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			
26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
27. Manner of Death 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 28d. Describe how injury occurred 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)	
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.			
29b. Signature and title of certifier <i>Manuel M. Exzamin MD</i>		29c. License number D19583	
29d. Date signed (Month, Day, Year) February 8, 2004		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MANUEL M. EXZAMIN MD 8 Law Street, Abingdon, Maryland 21001	
31. Date filed (Month, Day, Year) FEB 09 2004		32. Registrar's Signature <i>Beverly S. Sparks</i>	

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2004 03571

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Rose Shanay

2. Date of Death

Month
2

Day

5

Year

04

3. Time of Death

2:00 pm

4a. Facility Name (If not institution, give street and number)

Manor Care Rossville

4b. City, Town, or Location of Death

Rossville

4c. County of Death

Baltimore Co.

Funeral
Director

5. Social Security Number

213-12-4332

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

90

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

(Month, Day, Year)
Jan. 20, 1914

9. Birthplace (State or Foreign Country)

West Virginia

Usual Residence of Decedent

10a. State

Maryland

10b. County

Baltimore

10c. City, Town or Location

Dundalk

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

8103 Longpoint Road

10f. Zip Code

21222

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify:

White

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

6 Years

College (1-4or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

Joseph Martin

18. Mother's Name (First, Middle, Maiden Surname)

Mary Nemethy

19a. Informant's Name/Relationship (Type, Print)

Michele C. Barnes / Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

821 50th Street Dundalk, Maryland 21222

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Sacred Ht. of Jesus Cem. 2/9/2004 Dundalk, Maryland

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Duda-Ruck Funeral Home of Dundalk, Inc.

7922 Wise Ave. Dundalk, Maryland 21222

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

e. HYPOXIA

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Hours

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. PNEUMONIA

Due to (or as a consequence of):

c. Due to (or as a consequence of):d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

AIRWAY OBSTRUCTIONCONGESTIVE HEART FAILURE

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury

(Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier
(Check only one)1 ☒ Certifying Physician2 ☐ Medical Examiner

To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number

D55306

29d. Date signed (Month, Day, Year)

Feb 5th 2004

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DENNIS H. ODIE, 1232 RIVER RD, SUITE 305, BALTO MD 21237

31. Date filed (Month, Day, Year)

FEB 09 2004

32. Registrar's Signature

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2004 03572

1- For
State
RegistrarPhysician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

ARYANA SouthALL

2. Date of Death

February 1, 2004

3. Time of Death

8:20P^M

4a. Facility Name (If not institution, give street and number)

Greater Baltimore Medical Center

4b. City, Town, or Location of Death

Towson

4c. County of Death

Baltimore

5. Social Security Number

N/A

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

Yrs.

If Under 1 Year

Months

If Under 24 Hrs.

Days

Hours

Min.

8. Date of Birth

January 6, 2004

9. Birthplace (State or Foreign Country)

MD.

Usual Residence of Decedent

10a. State

MD

10b. County

BALTIMORE

10c. City, Town or Location

ESSEX

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

1108

10f. Zip Code

21221

10g. Citizen of What Country?

U.S.A

11. Marital Status

1 ☒ Never Married 2 ☐ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: BLACK

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

N/A

College (1-4 or 5+)

N/A

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

NEVER WORKED

16b. Kind of Business/Industry

N/A

17. Father's Name (First, Middle, Last)

Rywell SouthALL

18. Mother's Name (First, Middle, Maiden Surname)

Rochelle SUTTON

19a. Informant's Name/Relationship (Type, Print)

Rochelle SUTTON

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1108 TACE DR ESSEX MD 21221

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

OAKLAWN CEM.

Date

2/6/04

20c. Location - City or Town, State

Baltimore MD

21. Signature of Funeral Service Licensee

Paul Stilla

22. Name and Address of Facility

HARTLEY MILLER - STELLA FUNERAL HOME CHD.
7527 HARTLEY RD. Baltimore MD 2123423a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

a. Necrotizing enterocolitis

Due to (or as a consequence of):

b. Prematurity

Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate
Interval Between
Onset and Death

1 Day

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

IF FEMALE:

23b. Was decedent pregnant

in the past 12 months?
1 ☐ Yes 2 ☒ No
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy
4 ☐ Pregnant at time of death 5 ☐ Other (specify)
9 ☐ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an
autopsy
performed?
1 ☒ Yes 2 ☐ No24b. Were autopsy findings available
prior to completion of cause of
death?
1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation
6 ☐ Could not be determined

28a. Date of Injury

(Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature of title of certifier

Philip R. McDowell, M.D.

29c. License number

D47221

29d. Date signed (Month, Day, Year)

February 3, 2004

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Philip R. McDowell, M.D., 6701 N. Charles St., Baltimore MD, 21204

31. Date filed (Month, Day, Year)

FEB 09 2004

32. Registrar's Signature

[Signature]

State
Registrar

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28e-f show
any injury or other traumatic event, the Medical Examiner must be notified at
once.Physician
/Medical
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2004 03573

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Ashley

LYNN

Selander

2. Date of Death

February 3, 2004

3. Time of Death

12:05 AM

4a. Facility Name (If not institution, give street and number)

Johns Hopkins Hospital

4b. City, Town, or Location of Death

Baltimore City

4c. County of Death

N/A

5. Social Security Number

219-98-7114

6. Sex

1 ☐ M 2 ☒ F

7. Age (in yrs. last birthday)

21 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

MAY 31, 1982

9. Birthplace (State or Foreign Country)

MD.

Usual Residence of Decedent

10a. State

MD.

10b. County

N/A

10c. City, Town or Location

BALTIMORE

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

3507 DILLON STREET

10f. Zip Code

21224

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☒ Never Married 2 ☐ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)
SPECIAL EDUCATION

College (1-4or 5+)

16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

NEVER WORKED

16b. Kind of Business/Industry

N/A

17. Father's Name (First, Middle, Last)

UNKNOWN

18. Mother's Name (First, Middle, Maiden Surname)

MELISSA SELANDER

19a. Informant's Name/Relationship (Type, Print)

MELISSA SELANDER/MOTHER

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

3507 DILLON STREET, BALTIMORE, MARYLAND 21224

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

BALTIMORE WASHINGTON CREMATORY

Date

2/9/04 LAUREL, MARYLAND

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

Richard J. Lennet MD0521

22. Name and Address of Facility

CHARLES S. ZEILER & SON, INC.
6224 EASTERN AVE., BALTIMORE, MARYLAND 21224

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Respiratory Failure

5 days

Due to (or as a consequence of):

b. Atelectasis And Consolidation

3 weeks

Due to (or as a consequence of):

c. Severe mixed Central And Obstructive Apnea

8 years

Due to (or as a consequence of):

d. Spina Bifida, Arnold-Chiari Malformation, Hydrocephalus

21 years

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Richard J. Lennet MD0521

29c. License number

RES-000

29d. Date signed (Month, Day, Year)

2/3/04

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Patrick J. Graham 600 N. Wolfe St Baltimore, MD 21287

31. Date filed (Month, Day, Year)

FEB 09 2004

32. Registrar's Signature

[Signature]

State Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend Item #1 per phy G850 4/28/04 las

State of Maryland / Department of Health and Mental Hygiene

Amend Item 1,26 per Dr., G828,02/09/04dbb

Certificate of Death

Reg. No.

2004 03574

1- For State Registrar

Physician / Medical Examiner	1. Decedent's Name (First, Middle, Last) Justin Norbert Scharf			2. Date of Death Month 1 Day 20 Year 04		3. Time of Death 1103 AM	
	4a. Facility Name (If not institution, give street and number) Conrad Lodge			4b. City, Town, or Location of Death Hagerstown		4c. County of Death Washington	
Funeral Director	5. Social Security Number 206 14 7426		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 77 Yrs.		8. Date of Birth (Month, Day, Year) 7/24/26
	9. Birthplace (State or Foreign Country) unk						
To Be Completed by Funeral Director	Usual Residence of Decedent						
	10a. State MD		10b. County Washington		10c. City, Town or Location Hagerstown		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
	10e. Street and Number Econo Lodge 18821 Mason-Dixon Rd			10f. Zip Code 21740		10g. Citizen of What Country? USA	
	11. Marital Status unk <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: white
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) unk College (1-4 or 5+) unk			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) unk		16b. Kind of Business/Industry unk	
	17. Father's Name (First, Middle, Last) unk			18. Mother's Name (First, Middle, Maiden Surname) unk			
	19a. Informant's Name/Relationship (Type, Print) Dr. Kotch/Washington Co DME			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) unk			
	20a. Method of Disposition <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input checked="" type="checkbox"/> Other (Specify) in state			20b. Place of Disposition (Name of cemetery, crematory or other place)		20c. Location - City or Town, State	
	21. Signature of Funeral Service Licensee Ronald S. Wade, Director			22. Name and Address of Facility State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201			
	Physician / Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Atherosclerotic Cor Vascular Disease Due to (or as a consequence of): b. Diabetes Mellitus Due to (or as a consequence of): c. Hypertension Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last					
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Unknown <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Other (specify)		23d. Date of delivery Month Day Year			
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown	
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No						24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No	
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) Motel					
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No	
28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.							
29b. Signature and title of certifier [Signature], DEPUTY MEDICAL EXAMINER		29c. License number 00056965		29d. Date signed (Month, Day, Year) 1/20/04			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Stephen Joseph Kotch, MD 251 C Antietam Street Hagerstown, MD 21740							
State Registrar	31. Date filed (Month, Day, Year) FEB 09 2004		32. Registrar's Signature [Signature]				

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760, #1, 26

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2004 03575

1- For
State
Registrar

Certificate of Death

Reg. No.

Physician
/Medical
ExaminerFuneral
Director

1. Decedent's Name (First, Middle, Last)

EVELYN SCHWARTZ

2. Date of Death

FEBRUARY 04, 2004

3. Time of Death

11:45 P M

4a. Facility Name (If not institution, give street and number)

NORTHWEST HOSPITAL CENTER

4b. City, Town, or Location of Death

RANDALLSTOWN

4c. County of Death

BALTIMORE

5. Social Security Number

216-10-6096

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

88 Yrs.

If Under 1 Year

Months

If Under 24 Hrs.

Hours

8. Date of Birth

APR. 13, 1915

(Month, Day, Year)

9. Birthplace (State or Foreign Country)

MD

Usual Residence of Decedent

10a. State

MD

10b. County

BALTIMORE

10c. City, Town or Location

BALTIMORE

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

1601 WOODLING WAY

10f. Zip Code

21208

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: WHITE

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

HOMEMAKER

16b. Kind of Business/Industry

OWN HOME

17. Father's Name (First, Middle, Last)

WOLF

SAMET

18. Mother's Name (First, Middle, Maiden Surname)

FANNIE

ESTHER

ROTH

19a. Informant's Name/Relationship (Type, Print)

SHELDON SCHWARTZ / SON

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1601 WOODLING WAY - BALTIMORE, MD 21208

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Date

20c. Location - City or Town, State

BETH ISAAC ADATH ISRAEL 2/6/2004 DUNDALK, MD

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

SOL LEVINSON & BROS., INC.

8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Due to (or as a consequence of):

PNEUMONIA

Approximate Interval Between Onset and Death

3 DAYS

Sequentially list conditions,

if any leading to immediate

cause. Enter Underlying

Cause (Disease or injury

that initiated events

resulting in death) Last

c. Due to (or as a consequence of):

d.

IF FEMALE:

23b. Was decedent pregnant

in the past 12 months?
1 ☐ Yes 2 ☒ No
3 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
5 ☐ Other (specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an autopsy performed?
1 ☐ Yes 2 ☒ No24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation
2 ☐ Accident 6 ☐ Could not be determined
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury

(Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier
(Check only one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Joginder P Mehta, MD

29c. License number

D0041410

29d. Date signed (Month, Day, Year)

February 04, 2004

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

JOGINDER P MEHTA

31. Date filed (Month, Day, Year)

FEB 09 2004

32. Registrar's Signature

Joginder P Mehta

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.



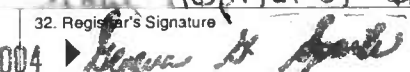
State of Maryland / Department of Health and Mental Hygiene

2004 03576

1- For
State
Registrar

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) JOSEPH I. SCHWAB						2. Date of Death Month February Day 3 Year 2004			3. Time of Death 730 A M	
	4a. Facility Name (If not institution, give street and number) Sinai Hospital of Baltimore						4b. City, Town, or Location of Death Baltimore City			4c. County of Death N/A	
Funeral Director	5. Social Security Number 091-30-1201		6. Sex 1 M 2 F		7. Age (In yrs. last birthday) 66 Yrs.		8. Date of Birth Month Jan Day 19 Year 1938		9. Birthplace (State or Foreign Country) NY		
	Usual Residence of Decedent										
10a. State MD		10b. County BALTIMORE		10c. City, Town or Location BALTIMORE				10d. Inside City Limits 1 Yes 2 No			
10e. Street and Number 4615 HORIZON CIRCLE #3				10f. Zip Code 21208			10g. Citizen of What Country? USA				
11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced			12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:			13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Yes 2 No Specify:			14. Race - American Indian, Black, White, etc. Specify: WHITE		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 2 College (1-4or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) CONVERTER				16b. Kind of Business/Industry TEXTILE			
17. Father's Name (First, Middle, Last) SAMUEL SCHWAB						18. Mother's Name (First, Middle, Maiden Surname) ROSE ROSENBERG					
19a. Informant's Name/Relationship (Type, Print) MRS. PHYLLIS ILLYEFALVI/SISTER						19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8207 DAREN COURT BALTIMORE, MD. 21208					
20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) CEDAR PARK		Date 2/6/2004		20c. Location - City or Town, State PARAMUS, NJ.			
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility SOL LEVINSON & BROS. INC. 8900 REISTERSTOWN ROAD PIKESVILLE, MD. 21208							
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Hepatic encephalopathy Due to (or as a consequence of): a. Hepatic encephalopathy b. c. d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last										Approximate Interval Between Onset and Death 3 days	
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown				23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify) 9 Unknown				23d. Date of delivery Month February Day 3 Year 2004			
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Diabetes, Hypertension, Benign Prostatic Hypertrophy, Intermittent Intussusception						23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown					
24a. Was an autopsy performed? 1 Yes 2 No				24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No							
25. Was case referred to medical examiner? 1 Yes 2 No				26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify)							
27. Manner of Death 1 Natural 5 Pending investigation 2 Accident 6 Could not be determined 3 Suicide 4 Homicide				28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 Yes 2 No		28d. Describe how injury occurred	
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)							
29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. Signature and title of certifier 				29c. License number RES-000		29d. Date signed (Month, Day, Year) February 3 2004	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) IK Sun MD Sinai Hospital of Baltimore											
31. Date filed (Month, Day, Year) FEB 09 2004				32. Registrar's Signature 							

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 202-343-0252.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2004 03577

1- For
State
RegistrarPhysician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

JAMES PHILIP SHOWERS

2. Date of Death

January 21 2004

3. Time of Death

7:40 M

Funeral
Director

4a. Facility Name (If not institution, give street and number)

Washington County Hospital

4b. City, Town, or Location of Death

Hagerstown

4c. County of Death

Washington

5. Social Security Number

234-01-9384

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

86 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth (Month, Day, Year)

August 16, 1917

9. Birthplace (State or Foreign Country)

West Virginia

Usual Residence of Decedent

10a. State

Maryland

10b. County

Washington

10c. City, Town or Location

Hagerstown

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

19808 Tranquility Circle

10f. Zip Code

21742

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Quality Supervisor

16b. Kind of Business/Industry

Aircraft Mfg.

17. Father's Name (First, Middle, Last)

Philip

Showers

18. Mother's Name (First, Middle, Maiden Surname)

Florence Louise Euglow

19a. Informant's Name/Relationship (Type, Print)

Ella Marie Showers Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

19808 Tranquility Circle, Hagerstown, Md. 21742

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Smithsburg Crematorium

Date

01-22-04

20c. Location - City or Town, State

Smithsburg, Maryland

21. Signature of Funeral Service Licensee

R. Joel Brady

22. Name and Address of Facility

Andrew K. Coffman Funeral Home, Inc.

40 East Antietam Street, Hagerstown, Md. 21740

23a. Part I. Enter the disease, or complication, that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Due to (or as a consequence of):

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Approximate Interval Between Onset and Death

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☒ No
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 5 ☐ Other (specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural 5 ☐ Pending investigation
2 ☐ Accident 6 ☐ Could not be determined
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Dr. Baron

29c. License number

D 53071

29d. Date signed (Month, Day, Year)

1-22-04

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Dr. Baron 11110 Medical Campus Rd. Htg. Md. 21742

31. Date filed (Month, Day, Year)

FEB 09 2004

32. Registrar's Signature

John A. Smith

ORIGINAL

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
ExaminerTo the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2004 03578

1- For
State
Registrar

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permi. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Physician
/Medical
ExaminerFuneral
Director

1. Decedent's Name (First, Middle, Last) Lillie May Stewart		2. Date of Death Month Feb. Day 3 Year 2004		3. Time of Death 4:27 AM	
4a. Facility Name (If not institution, give street and number) John Hopkins Hospital		4b. City, Town, or Location of Death Baltimore		4c. County of Death n/a	
5. Social Security Number 212-32-6298		6. Sex 1 M		7. Age (In yrs. last birthday) 70 Yrs.	
8. Date of Birth (Month, Day, Year) Mar 22, 1933		9. Birthplace (State or Foreign Country) MD			
10a. State MD		10b. County N/A		10c. City, Town or Location Baltimore	
10d. Inside City Limits 1 X Yes 2 No		10e. Street and Number 1105 N. Kenwood Ave.		10f. Zip Code 21213	
10g. Citizen of What Country? U.S.A.		11. Marital Status 2 X Married		12. Was Decedent Ever in U.S. Armed Forces? 1 No 2 X Yes	
13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 No 2 X Yes		14. Race - American Indian, Black, White, etc. Specify: Black			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Nurses Aide		16b. Kind of Business/Industry Sinai Hospital	
17. Father's Name (First, Middle, Last) Phillip Hudson		18. Mother's Name (First, Middle, Maiden Surname) Minnie Clifford			
19a. Informant's Name/Relationship (Type, Print) Russell Stewart/Husband		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1105 N. Kenwood Ave. Baltimore, MD 21213			
20a. Method of Disposition 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Druid Ridge Cem		20c. Location - City or Town, State Feb. 10, 2004 Pikesville, MD	
21. Signature of Funeral Service Licensee 		22. Name and Address of Facility CALVIN B. SCRUGGS FUNERAL HOME 1412 E. PRESTON STREET BALTO. MD 21213			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. BREAST CANCER WITH WIDESPREAD METASTASES		23b. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. HYPERTENSIVE CARDIOVASCULAR DISEASE DIABETES MELLITUS, INSULIN DEPENDENT CHRONIC RENAL INSUFFICIENCY		23c. Did tobacco use contribute to the cause of death? 1 No 2 X Yes 3 Probably 4 Unknown	
23d. Date of delivery Month Feb Day 10 Year 2004		24a. Was an autopsy performed? 1 No 2 X Yes		24b. Were autopsy findings available prior to completion of cause of death? 1 No 2 X Yes	
25. Was case referred to medical examiner? 1 No 2 X Yes		26. Place of Death (Check only one) 1 Inpatient 2 X ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify)		27. Manner of Death 1 X Natural 2 Accident 3 Suicide 4 Homicide 5 Pending investigation 6 Could not be determined	
28a. Date of Injury (Month, Day Year) Feb 10 2004		28b. Time of Injury M		28c. Injury at Work? 1 No 2 Yes	
28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State) BALTIMORE MD. 21216	
29a. Certifier (Check only one) 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier Dr. W. Stewart, M.D.		29c. License number D10790	
29d. Date signed (Month, Day, Year) 2/4/04		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) D.W. STEWART, M.D.: 222 W. COLD SPRING LANE		31. Date filed (Month, Day, Year) FEB 09 2004	
32. Registrar's Signature 					

State
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2004 03579

1- For
State
RegistrarPhysician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Mary Catherine Ulrich

2. Date of Death

Month Day Year
February 4, 2004

3. Time of Death

2:30 A M

Funeral
Director

4a. Facility Name (If not institution, give street and number)

Millennium Health Center

4b. City, Town, or Location of Death

Edgewater

4c. County of Death

Anne Arundel

5. Social Security Number

226-14-9689

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

84

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
Nov. 29, 1919

9. Birthplace (State or Foreign Country)

West Virginia

Usual Residence of Decedent

10a. State

10b. County

Maryland Anne Arundel

10c. City, Town or Location

Harwood

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

1502 H Flanders Lane

10f. Zip Code

20776

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)
8th

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Cook

16b. Kind of Business/Industry

School System

17. Father's Name (First, Middle, Last)

unknown Lally

18. Mother's Name (First, Middle, Maiden Surname)

unknown

19a. Informant's Name/Relationship (Type, Print)

Deborah L. Coleman/ Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1502 H Flanders Lane, Harwood, MD 20776

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Kalas Crematory

Date

2-5-04

20c. Location - City or Town, State

Edgewater, MD

21. Signature of Funeral Service Licensee

Deborah L. Coleman

22. Name and Address of Facility

George P. Kalas Funeral Home
2973 Solomons Island Rd. Edgewater, MD 21037

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Cardiac Arrhythmia

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. General Debility

Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☒ No
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 5 ☐ Other (specify)
9 ☐ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Deborah L. Coleman

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an autopsy performed?
1 ☐ Yes 2 ☒ No24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☒ No25. Was case referred to medical examiner?
1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA
Other: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?
1 ☐ Yes 2 ☒ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Deborah L. Coleman

29c. License number

D57028

29d. Date signed (Month, Day, Year)

February 4, 2004

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ADITYA CHOPRA, MD 100 Ridgely Ave Ste 231 Annapolis, MD 21401

31. Date filed (Month, Day, Year)

FEB 09 2004

32. Registrar's Signature

Deborah L. Coleman

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23b or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2004 03580

1- For
State
RegistrarPhysician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Sarah Elizabeth Trimble

2. Date of Death
Month Day Year

2 2 2004 5:47 P M

3. Time of Death

Funeral
Director

4a. Facility Name (If not institution, give street and number)

FRANKLIN SQUARE HOSPITAL

4b. City, Town, or Location of Death

ROSEDALE

4c. County of Death

BALTIMORE

5. Social Security Number

163-24-4720

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

82 Yrs.

If Under 1 Year

Months

If Under 24 Hrs.

Hours

8. Date of Birth

(Month, Day, Year)

7/28/1921

9. Birthplace (State or Foreign Country)

Pennsylvania

Usual Residence of Decedent

10a. State

Maryland

10b. County

Baltimore

10c. City, Town or Location

Essex

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

6 Mingo Lane

10f. Zip Code

21221

10g. Citizen of What Country?

U. S. A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify:

White

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

8

College (1-4or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

Cook

16b. Kind of Business/Industry

Restaurant

17. Father's Name (First, Middle, Last)

Jesse Lewis Snyder

18. Mother's Name (First, Middle, Maiden Surname)

Jennie Margaret Kalp

19a. Informant's Name/Relationship (Type, Print)

Ernest Trimble (Son)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

6 Mingo Lane Essex, Maryland 21221

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Gardens of Faith Cem.

Date

2/5

2004

20c. Location - City or Town, State

Baltimore, Maryland

21. Signature of Funeral Service Licensee

Michael C. Gaffran Sr.

22. Name and Address of Facility

Bruzdinski Funeral Home PA

1407 Old Eastern Avenue Essex, Maryland 21221

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,

shock, or heart failure. List only one cause on each line.

Approximate
Interval Between
Onset and DeathImmediate Cause (Final
disease or condition
resulting in death)

a. Severe Sepsis

Due to (or as a consequence of):

b. Pneumonia

Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

36 HOURS

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

IF FEMALE:

23b. Was decedent pregnant
in the past 12 months?1 ☐ Yes 2 ☒ No9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death4 ☐ Pregnant at time of death9 ☐ Unknown3 ☐ Ectopic pregnancy5 ☐ Other (specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

CHRONIC RENAL FAILURE

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an
autopsy performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings available
prior to completion of cause of
death?1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident3 ☐ Suicide 4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury

(Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier
(Check only one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

J. L. M. M.D.

29c. License number

DS3462

29d. Date signed (Month, Day, Year)

2/2/04

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DR. Jude Muneses 9000 FRANKLIN SQUARE DR. BALTIMORE Md 21237

31. Date filed (Month, Day, Year)

FEB 09 2004

32. Registrar's Signature

Jenna B. Sparks

State
Registrar

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit card.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2004 03581

1- For
State
RegistrarPhysician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Joseph I. Vitek

2. Date of Death

Month Day Year
FEBRUARY 5, 2004

3. Time of Death

12:23A^MFuneral
Director

4a. Facility Name (If not institution, give street and number)

Saint Joseph Medical Center

4b. City, Town, or Location of Death

Towson

4c. County of Death

Baltimore

5. Social Security Number

214-03-2880

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

85 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Month Day Year
July 2, 1918

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

MD

10b. County

Queen Anne's

10c. City, Town or Location

Stevensville

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

100 Point Road

10f. Zip Code

21666

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☒ Yes 2 ☐ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: white

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4or 5+)

4

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Manufacturing Engineer

16b. Kind of Business/Industry

Aerospace

17. Father's Name (First, Middle, Last)

Ignatius Joseph Vitek

18. Mother's Name (First, Middle, Maiden Surname)

Marie Kalus

19a. Informant's Name/Relationship (Type, Print)

Joseph P. Vitek / son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

301 Oxbow Drive; Stevensville, MD 21666

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Gardens of Faith

Date

2/9/04

20c. Location - City or Town, State

Baltimore, MD

21. Signature of Funeral Home Licensee

22. Name and Address of Facility

Ruck Towson Funeral Home

1050 York Road

Towson, MD 21204

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. VENTRICULAR ARRHYTHMIA

Due to (or as a consequence of):

b. CORONARY ARTERY DISEASE

Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☐ No
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 5 ☐ Other (specify)
9 ☐ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

HYPERLIPIDEMIA

HYPOTHYROIDISM

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation
2 ☐ Accident 6 ☐ Could not be determined
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D 37254

29d. Date signed (Month, Day, Year)

2/5/04

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

BOON P. LIM M.D. 7601 OSLER DRIVE TOWSON MARYLAND 21204

31. Date filed (Month, Day, Year)

FEB 09 2004

32. Registrar's Signature

[Signature]

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 23e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2004 03582

1- For State Registrar

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)

Melvin James White Sr

2. Date of Death

Month Day Year

Feb 4 2004

3. Time of Death

3 50 a m

4a. Facility Name (If not institution, give street and number)

Franklin Square Hospital Center

4b. City, Town, or Location of Death

Rosedale

4c. County of Death

Baltimore

5. Social Security Number

220 30 4660

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

69

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth (Month, Day, Year)

December 19 1934

9. Birthplace (State or Foreign Country)

Pennsylvania

Usual Residence of Decedent

10a. State

Maryland

10b. County

Baltimore City

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

408 Old Home Road

10f. Zip Code

21206

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☒ Yes 2 ☐ No
If Yes, Give Year or Dates: WW II

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

N/A

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Machine Operator

16b. Kind of Business/Industry

Victory Racing Plate Co.

17. Father's Name (First, Middle, Last)

Samuel Ellsworth White

18. Mother's Name (First, Middle, Maiden Surname)

Anna Marie Mauery

19a. Informant's Name/Relationship (Type, Print)

Patricia R White

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

408 Old Home Road Baltimore, Maryland 21206

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Oak Lawn Cemetery February 9 2004

Date

20c. Location - City or Town, State

Baltimore, Maryland

21. Signature of Funeral Service Licensee

Michael J. Chomicki

22. Name and Address of Facility

Lassahn Funeral Home Inc
7401 Belair Road Baltimore, Maryland 21236

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Empyema

Due to (or as a consequence of):

b. Bronchopleural fistula

Due to (or as a consequence of):

c. Pneumonectomy

Due to (or as a consequence of):

d. Bronchogenic carcinoma

Approximate Interval Between Onset and Death

1 month

2 months

2 months

2 months

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☒ No
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 5 ☐ Other (specify)
9 ☐ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Peripheral vascular disease
COPD

23e. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ OOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

M 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Audrey Liu M.D.

29c. License number

D0059526

29d. Date signed (Month, Day, Year)

2/04/04

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

AUDREY LIU 9000 Franklin Square Drive Baltimore, Md. 21237

31. Date filed (Month, Day, Year)

FEB 09 2004

32. Registrar's Signature

[Signature]

State Registrar

White, Melvin
Baltimore, Maryland 21215-0036

perml. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

To Be Completed by Funeral Director

Medical Certification; To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2004 03583

Physician
/Medical
Examiner

Funeral
Director

1. Decedent's Name (First, Middle, Last) Herbert Oliver Wilder		2. Date of Death Month February Day 2 Year 2004		3. Time of Death 4:00pm
4a. Facility Name (If not institution, give street and number) Lorien Oliver's Inc		4b. City, Town, or Location of Death Beltan		4c. County of Death HARFORD
5. Social Security Number 705-09-8296	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 92 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.
8. Date of Birth (Month, Day, Year) 02/13/1911		9. Birthplace (State or Foreign Country) Maryland		
Usual Residence of Decedent				
10a. State MD	10b. County Harford	10c. City, Town or Location Forest Hill		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
10e. Street and Number 1909 Treeline Drive		10f. Zip Code 21050		10g. Citizen of What Country? U.S.A.
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:
14. Race - American Indian, Black, White, etc. Specify: White		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+)		
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Supervisor		16b. Kind of Business/Industry B & O Railroad		
17. Father's Name (First, Middle, Last) Herbert Herman Wilder		18. Mother's Name (First, Middle, Maiden Surname) Olive A. Brown		
19a. Informant's Name/Relationship (Type, Print) Herbert C. Wilder (son)		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2408 Gilwood Drive - Joppa, MD 21085		
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Highview Memorial Gdns.		20c. Location - City or Town, State 02/05/04 Fallston, Maryland
21. Signature of Funeral Service Licensee E. F. Lassahn		22. Name and Address of Facility E. F. Lassahn Funeral Home, P.A. 11750 Belair Road - Kingsville, MD 21087		
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.				
Immediate Cause (Final disease or condition resulting in death) a. Myocardial infarction Due to (or as a consequence of):				
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of):				
c. Due to (or as a consequence of):				
d. Due to (or as a consequence of):				
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Hypertension, Aneurysm				
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown				
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No				
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M
28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred		
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)		
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				
29b. Signature and title of certifier Dr. C. Allen		29c. License number 027975		29d. Date signed (Month, Day, Year) 2/3/04
30. Name and address of person who completed cause of death (Item 23e). (Type, Print) Dr. C. Allen 615 Mac Millan Rd Bel Air, MD 21034				
31. Date filed (Month, Day, Year) FEB 09 2004		32. Registrar's Signature John B. Smith		

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Herbert O. Wilder
Baltimore, Maryland 21215-0020
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 24a show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2004 03584

1- For State Registrar AMEND ITEM #5 PER FH G828 2/24/04 Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Frank Raymond Woelfer				2. Date of Death Month Day Year February 4, 2004		3. Time of Death 4:42 A M	
	4a. Facility Name (If not institution, give street and number) 400 Stefan Court				4b. City, Town, or Location of Death Dundalk		4c. County of Death Baltimore	
Funeral Director	5. Social Security Number 212-30-0963		6. Sex M F M		7. Age (In yrs. last birthday) Yrs. 70		8. Date of Birth (Month, Day, Year) Oct. 1, 1933	
	9. Birthplace (State or Foreign Country) Maryland		10a. State Maryland		10b. County Baltimore		10c. City, Town or Location Dundalk	
To Be Completed by Funeral Director	10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		10e. Street and Number 400 Stefan Court		10f. Zip Code 21222		10g. Citizen of What Country? United States	
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 10 Years College (1-4 or 5+) 10 Years		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Baker		16b. Kind of Business/Industry Self Employed			
	17. Father's Name (First, Middle, Last) Frank Woelfer				18. Mother's Name (First, Middle, Maiden Surname) Ruby Clapp			
	19a. Informant's Name/Relationship (Type, Print) Mrs. Ann L. Woelfer / Wife				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 400 Stefan Court Dundalk, Maryland 21222			
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Meadowridge Mem. Park		20c. Location - City or Town, State Dorsey, Maryland			
	21. Signature of Funeral Service Licensee 		22. Name and Address of Facility Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 21222					
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. ORAL CANCER Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last							
	IF FEMALE 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) 9 <input type="checkbox"/> Unknown		23d. Date of delivery Month Day Year			
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input checked="" type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown	
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No						
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other (Specify) HOSPICE						
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
29b. Signature and title of certifier 		29c. License number D0057281		29d. Date signed (Month, Day, Year) 2/4/2004				
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) IWABENA OSEI-BOATENG, 4920 Campbell Blvd, Baltimore MD 21236								
31. Date filed (Month, Day, Year) FEB 09 2004		32. Registrar's Signature 						

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified in advance.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2004 03585

1- For
State
Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <u>Lawrence Wenchel, JR</u>			2. Date of Death Month <u>Feb</u> Day <u>6</u> Year <u>2004</u>		3. Time of Death <u>8:00 A M</u>	
	4a. Facility Name (If not institution, give street and number) <u>OAKCREST VILLAGE NURSING HOME</u>			4b. City, Town, or Location of Death <u>PARKVILLE</u>		4c. County of Death <u>BALTIMORE</u>	
Funeral Director	5. Social Security Number <u>213-09-9240</u>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <u>94</u> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <u>OCT 5, 1909</u>
	9. Birthplace (State or Foreign Country) <u>MD</u>						
To Be Completed by Funeral Director	Usual Residence of Decedent						
	10a. State <u>MD</u>	10b. County <u>BALTIMORE</u>	10c. City, Town or Location <u>Parkville</u>			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	10e. Street and Number <u>8832 WALTER BLVD.</u>			10f. Zip Code <u>21234</u>		10g. Citizen of What Country? <u>U.S.A.</u>	
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <u>White</u>
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <u>12th</u> College (1-4 or 5+) <u>N/A</u>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <u>Photographer</u>		16b. Kind of Business/Industry <u>MD Tech Corp.</u>		
To Be Completed by Physician/Medical Examiner	17. Father's Name (First, Middle, Last) <u>Lawrence Wenchel, SR</u>			18. Mother's Name (First, Middle, Maiden Surname) <u>ANNA Meidling</u>			
	19a. Informant's Name/Relationship (Type, Print) <u>JEAN BYASSEE</u>			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>100 DURSO DR, NEWARK DE. 19711</u>			
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <u>PARKWOOD CEMETERY</u>		20c. Location - City or Town, State <u>BALTO MD.</u>		
	21. Signature of Funeral Service Licensee <u>Paul M. Stella</u>		22. Name and Address of Facility <u>HARTLEY MILLER - ST.ELLA FUNERAL HOME CHD.</u> <u>7527 HARTFORD RD. BALTO. MD 21234</u>				
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) <u>Arteriosclerotic vascular disease</u>					Approximate Interval Between Onset and Death <u>years</u>	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last			a. Due to (or as a consequence of):				
			b. Due to (or as a consequence of):				
			c. Due to (or as a consequence of):				
			d. Due to (or as a consequence of):				
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown			23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <input type="checkbox"/> Unknown		23d. Date of delivery Month Day Year		
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>previous OVA, atrial fibrillation, congestive heart failure, chronic renal failure</u>			23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown		24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
			24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)				
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide			28a. Date of Injury (Month, Day Year)		28b. Time of Injury <u>M</u>		
			28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred		
			28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)		
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.			29b. Signature and title of certifier <u>Kendall R. Faulkes</u>		29c. License number <u>D25643</u>		
			29d. Date signed (Month, Day, Year) <u>02/06/2004</u>				
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <u>Kendall R. Faulkes MD/8800 Walter Blvd/Balto MD 21234</u>							
31. Date filed (Month, Day, Year) <u>FEB 09 2004</u>			32. Registrar's Signature <u>Geneva B. Sparks</u>				

TERRI WOODEN
04-00978
DAP

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2004 03586

1- For State Registrar Unpend Item 23a, 27, 28a-f, Per ME, 0809/11/04 Reg of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Terri Wooden		2. Date of Death Month Day Year FEBRUARY 4, 2004		3. Time of Death 1:35 a M	
	4a. Facility Name (If not institution, give street and number) SINAI HOSPITAL		4b. City, Town, or Location of Death BALTIMORE CITY		4c. County of Death N/A	
Funeral Director	5. Social Security Number 213-63-5662	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 49 Yrs.	8. Date of Birth (Month, Day, Year) Dec. 23, 1954	9. Birthplace (State or Foreign Country) Maryland	
	10a. State md.		10b. County N/A	10c. City, Town or Location Baltimore		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
To Be Completed by Funeral Director	10e. Street and Number 805 Newington Ave		10f. Zip Code 21217		10g. Citizen of What Country? USA	
	11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:	
To Be Completed by Physician/Medical Examiner	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12th College (1-4 or 5+) N/A		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Assembly Line Worker		16b. Kind of Business/Industry Baltimore Electronics	
	17. Father's Name (First, Middle, Last) Curtis E. Wooden		18. Mother's Name (First, Middle, Maiden Surname) Evelyn Hughes			
Physician /Medical Examiner	19a. Informant's Name/Relationship (Type, Print) Bernadette Wooden - Sister		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2715 W. Belvedere Dr. Balt. md. 21215			
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Voshell mem. Gard		20c. Location - City or Town, State 2-9-04 Dundalk, md.	
To Be Completed by Physician/Medical Examiner	21. Signature of Funeral Service Licensee Nancy M. Wallace		22. Name and Address of Facility 3405 W. Rankin St. Balt. md. 21229 Nancy M. Wallace Funeral Service			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Complications of Remote Gunshot Wound To The Abdomen		Approximate Interval Between Onset and Death			
To Be Completed by Physician/Medical Examiner	23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Unknown		23d. Date of delivery Month Day Year	
	24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No			
To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined	
	28a. Date of Injury (Month, Day, Year) 2/13/08		28b. Time of Injury 10:22 pm		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
To Be Completed by Physician/Medical Examiner	28d. Describe how injury occurred subject was shot		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) roadway		28f. Location (Street and Number or Rural Route Number, City or Town, State) Etting and Baker St., Baltimore, MD	
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier Quatr		29c. License number OCME	
To Be Completed by Physician/Medical Examiner	29d. Date signed (Month, Day, Year) FEBRUARY , 2004		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) AND. RUBIO, MD 111 Penn Street, Baltimore, Maryland 21201			
	31. Date filed (Month, Day, Year) FEB 09 2004		32. Registrar's Signature [Signature]			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2004 03587

1- For State Registrar

Physician / Medical Examiner	1. Decedent's Name (First, Middle, Last) Elijah Wilson				2. Date of Death Month FEBRUARY Day 3 Year 2004		3. Time of Death 4:32 P. M	
	4a. Facility Name (If not institution, give street and number) JOHNS HOPKINS BAYVIEW MEDICAL CENTER				4b. City, Town, or Location of Death BALTIMORE CITY		4c. County of Death n/a	
Funeral Director	5. Social Security Number 245-56-2695		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 65 Yrs.		8. Date of Birth (Month, Day, Year) Oct. 7, 1938	
	9. Birthplace (State or Foreign Country) North Carolina		10a. State MD		10b. County n/a		10c. City, Town or Location Baltimore	
To Be Completed by Funeral Director	10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		10e. Street and Number 2019 E. Belvedere Ave.		10f. Zip Code 21239		10g. Citizen of What Country? U.S.A.	
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: Black	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 10th College (1-4or 5+) Machine Operator		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)		16b. Kind of Business/Industry Cambridge Iron Co.			
	17. Father's Name (First, Middle, Last) Unknown		18. Mother's Name (First, Middle, Maiden Surname) Nellie Wilson		19a. Informant's Name/Relationship (Type, Print) Joann Wilson/wife		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2019 E. Belvedere Ave. Balto. MD 21239	
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Garden Of Faith Cem		20c. Location - City or Town, State Baltimore, MD		20d. Date Feb. 9, 2004	
	21. Signature of Funeral Service Licensee 		22. Name and Address of Facility CALVIN B. SCRUGGS FUNERAL HOME 1412 E. PRESTON STREET BALTO. MD 21213					
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. ATHEROSCLEROTIC CARDIOVASCULAR DISEASE Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		23b. If FEMALE: Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <input type="checkbox"/> Unknown		23d. Date of delivery Month Day Year	
	23e. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No			
	25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year) 28b. Time of Injury M 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No 28d. Describe how injury occurred 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)	
	29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier 		29c. License number O.C.M.E.		29d. Date signed (Month, Day, Year) FEBRUARY 4, 2004	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ANA RUBIO, MD		31. Date filed (Month, Day, Year) FEB 09 2004		32. Registrar's Signature 				

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2004 03588

1- For
State
RegistrarPhysician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Sadie Rebecca Yoak

2. Date of Death

Month 02 Day 02 Year 04

3. Time of Death

10:50 AM

4a. Facility Name (If not institution, give street and number)

Sacred Heart Hospital

4b. City, Town, or Location of Death

Cumberland

4c. County of Death

Allegany

Funeral
Director

5. Social Security Number

232-26-3357

6. Sex

☐ M ☒ F

7. Age (In yrs. last birthday)

99 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
April 17, 1904

9. Birthplace (State or Foreign Country)

West Virginia

Usual Residence of Decedent

10a. State

WV

10b. County

Mineral

10c. City, Town or Location

Keyser

10d. Inside City Limit

☒ Yes ☐ No

10e. Street and Number

47 "D" Street

10f. Zip Code

26726

10g. Citizen of What Country?

USA

11. Marital Status

☐ Never Married ☐ Married
☒ Widowed ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

☐ Yes ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

☐ Yes ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

4

College (1-4or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

George Swick

18. Mother's Name (First, Middle, Maiden Surname)

Mollie Borrer

19a. Informant's Name/Relationship (Type, Print)

Sharon Winkler/ Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

47 "D" Street Keyser, WV 26726

20a. Method of Disposition

☒ Burial ☐ Cremation ☐ Removal from State
☐ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Potomac Memorial Gardens

Date

Feb. 5

20c. Location - City or Town, State

Keyser, WV

21. Signature of Funeral Service Licensee

Brian F. Smith

22. Name and Address of Facility

Smith Funeral Home

85 S. Main Street Keyser, WV 26726

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. SEPSIS SYNDROME

Approximate Interval Between Onset and Death

About 1 week

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. BILATERAL PNEUMONIA

about 1 week

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

☐ Yes ☒ No ☐ Unknown

23c. If yes, outcome of pregnancy

☐ Live birth ☐ Fetal death ☐ Ectopic pregnancy
☐ Pregnant at time of death ☐ Other (specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

UROSEPSIS DEHYDRATION

23e. Did tobacco use contribute to the cause of death?

☐ Yes ☒ No ☐ Probably ☒ Unknown

24a. Was an autopsy performed?

☐ Yes ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

☐ Yes ☒ No

25. Was case referred to medical examiner?

☐ Yes ☒ No

Hospital:

☒ Inpatient ☐ ER/Outpatient ☐ DOA

26. Place of Death (Check only one)

Other: ☐ Nursing Home ☐ Residence ☐ Other (Specify)

27. Manner of Death

☒ Natural ☐ Pending investigation
☐ Accident ☐ Could not be determined
☐ Suicide ☐ Homicide

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

☐ Yes ☒ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

H. Smith MD

29c. License number

D26907

29d. Date signed (Month, Day, Year)

FEBRUARY 2, 2004

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

HARTI SIDHU 925 BISHOP WALSH ROAD CUMBERLAND, MD. 21502

31. Date filed (Month, Day, Year)

FEB 09 2004

32. Registrar's Signature

[Signature]

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2004 03589

1- For
State
RegistrarPhysician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

ETHEL MAE WARD PIGMAN ARNOLD

2. Date of Death

January 17, 2004

3. Time of Death

12:15P M

Funeral
Director

4a. Facility Name (If not institution, give street and number)

Anchorage Nursing & Rehabilitation

4b. City, Town, or Location of Death

Salisbury

4c. County of Death

Wicomico

5. Social Security Number

213-24-4589

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

73 Yrs.

8. Date of Birth

Mar. 4, 1930

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

MD

10b. County

Worcester

10c. City, Town or Location

Pocomoke City

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

2353 Klej Grange Road

10f. Zip Code

21851

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4or 5+)

11

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Bookkeeper

16b. Kind of Business/Industry

Retail

17. Father's Name (First, Middle, Last)

Robert Lee Ward, Sr.

18. Mother's Name (First, Middle, Maiden Surname)

Edna Francis White

19a. Informant's Name/Relationship (Type, Print)

Leona Hill/ Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1626 New Bridge Road, Pocomoke City, MD 21851

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory, or other place)

Salisbury Crematory

Date

1/23/04

20c. Location - City or Town, State

Salisbury, MD 21804

21. Signature of Funeral Service Licensee

Michael A. Dean 1/23/04

22. Name and Address of Facility

Holloway Melson Funeral Home, P.A.
103 Linden Ave., Pocomoke City, MD 21851

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. *Gastric Cancer*
Due to (or as a consequence of):

Approximate Interval Between Onset and Death

24 min

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☐ No
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown3 ☐ Ectopic pregnancy5 ☐ Other (specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Nathan

29c. License number

047094

29d. Date signed (Month, Day, Year)

1/19/04

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Vel NATEGAN

1415 S. Division Street

Salisbury MD 21804

31. Date filed (Month, Day, Year)

JAN 22 2004

32. Registrar's Signature

*James H. Spiller*State
Registrar

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2004 03590

1- For
State
RegistrarPhysician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

David L Auclair

2. Date of Death

January 17th 2004

3. Time of Death

10:02 a.m.

Funeral
Director

4a. Facility Name (If not institution, give street and number)

Howard County General Hosp.

4b. City, Town, or Location of Death

Columbia

4c. County of Death

Howard

5. Social Security Number

126 18 9221

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

80

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth (Month, Day, Year)

March 23, 1923

9. Birthplace (State or Foreign Country)

New Hampshire

Usual Residence of Decedent

10a. State

MD

10b. County

Howard

10c. City, Town or Location

Columbia

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

6500 Freetown Road

10f. Zip Code

21044

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☒ Yes 2 ☐ No
If Yes, Give Year or Dates: 1942-45

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)
12

College (1-4or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

CEO

16b. Kind of Business/Industry

Air Exchange

17. Father's Name (First, Middle, Last)

Dorilla Auclair

18. Mother's Name (First, Middle, Maiden Surname)

Elsie Camm

19a. Informant's Name/Relationship (Type, Print)

Nancy Auclair/Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

10025 Emily Fox Court Ellicott City, MD 21042

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Metro Crematory

Date

1-19-2004

20c. Location - City or Town, State

Catonsville, MD

21. Signature of Funeral Service Licensee

M01044

Harry H. Witzke

22. Name and Address of Facility

Harry H. Witzke's Family FH Inc.
4112 Old Columbia Pike Ellicott City, MD 21043

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

a. Due to (or as a consequence of):

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Septic Shock

Hypertension

Type I Diabetes

Approximate Interval Between Onset and Death

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☐ No
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown3 ☐ Ectopic pregnancy5 ☐ Other (specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Stroke

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Susan Ardo

29c. License number

DS0870

29d. Date signed (Month, Day, Year)

January 17th 2003

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Susan Ardo 5005 Signal Bell Lane Clarksville MD 21029

31. Date filed (Month, Day, Year)

JAN 20 2004

32. Registrar's Signature

Susan B. Ardo

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2004 03591

1- For
State
RegistrarPhysician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Kevin Daun Armour

2. Date of Death

January 9, 2004

3. Time of Death

11:55A M

4a. Facility Name (If not institution, give street and number)

11604 Rope Knot Road

4b. City, Town, or Location of Death

Lusby

4c. County of Death

Calvert

Funeral
Director

5. Social Security Number

235 78 9881

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

54

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

(Month, Day, Year)

Sept 19 1949

9. Birthplace (State or Foreign Country)

West Virginia

Usual Residence of Decedent

10a. State

Maryland

10b. County

Calvert

10c. City, Town or Location

Lusby

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

11604 Rope Knot Road

10f. Zip Code

20657

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☒ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☐ No

If Yes, Give Year or Dates

68

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: white

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

1

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

service manager

16b. Kind of Business/Industry

vending company

17. Father's Name (First, Middle, Last)

John William Armour

18. Mother's Name (First, Middle, Maiden Surname)

Lucille Radabaugh

19a. Informant's Name/Relationship (Type, Print)

Cindy Armour- wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

11604 Rope Knot Rd. Lusby MD 20657

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Metropolitan Funeral Service

Date

Jan 10 2004

20c. Location - City or Town, State

Alexandria Virginia

21. Signature of Funeral Service Licensee

B. Rausch

22. Name and Address of Facility

4405 Brookes Is. rd. Port Republic MD 20676

Rausch Funeral Home

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Pulmonary Fibrosis

Approximate Interval Between Onset and Death

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

- a. Due to (or as a consequence of):
- b. Due to (or as a consequence of):
- c. Due to (or as a consequence of):
- d. Due to (or as a consequence of):

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☐ No9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death4 ☐ Pregnant at time of death9 ☐ Unknown3 ☐ Ectopic pregnancy5 ☐ Other (specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☒ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined6 ☐ Could not be determined6 ☐ Could not be determined6 ☐ Could not be determined6 ☐ Could not be determined6 ☐ Could not be determined6 ☐ Could not be determined6 ☐ Could not be determined6 ☐ Could not be determined6 ☐ Could not be determined6 ☐ Could not be determined6 ☐ Could not be determined6 ☐ Could not be determined6 ☐ Could not be determined6 ☐ Could not be determined6 ☐ Could not be determined6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

J. John Barth III MD

29c. License number

D0052242

29d. Date signed (Month, Day, Year)

Jan. 9, 2004

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

J. John Barth III MD Prince Frederick MD 20676

31. Date filed (Month, Day, Year)

JAN 12 2004

32. Registrar's Signature

K. B. Smith

Baltimore, Maryland 21215-0036

perml. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural" or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To Be Completed by Funeral Director

Medical Certification; To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Division of Vital Records, P.O. Box 68760,

State
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2004 03592

1- For
State
RegistrarPhysician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Thomas A. Brooks

2. Date of Death

January 23, 2004

3. Time of Death

4:33 P M

4a. Facility Name (If not institution, give street and number)

2172 Bonnie Lane

4b. City, Town, or Location of Death

Waldorf

4c. County of Death

Charles

Funeral
Director

5. Social Security Number

021-10-5395

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

89

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Aug. 11, 1914

9. Birthplace (State or Foreign Country)

England

Usual Residence of Decedent

10a. State

MD

10b. County

Charles

10c. City, Town or Location

Waldorf

10d. Inside City Limits

1 ☐ Yes ☒ No

10e. Street and Number

2172 Bonnie Lane

10f. Zip Code

20601

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

1 ☒ Yes 2 ☐ No
If Yes, Give
Year or Date

1936-1945

13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: white

15. Decedent's Education
(Specify only highest grade completed)Elementary/Secondary (0-12)
12

College (1-4 or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Manager

16b. Kind of Business/Industry

Farm and Home Supply

17. Father's Name (First, Middle, Last)

George Brooks

18. Mother's Name (First, Middle, Maiden Surname)

Florrie Woodhouse

19a. Informant's Name/Relationship (Type, Print)

Evelyn Doris Brooks-wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2172 Bonnie Lane, Waldorf, MD 20601

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

St. Peter's Cemetery

Date

01-27-2004 Waldorf, Maryland

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

Jack A. Wilson

M01246

22. Name and Address of Facility

HUNTT FUNERAL HOME

P.O. BOX 156, WALDORF, MARYLAND 20604

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

a. LUNG CANCER

Due to (or as a consequence of):

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate
Interval Between
Onset and Death

3 MONTHS

IF FEMALE:

23b. Was decedent pregnant
in the past 12 months?1 ☐ Yes 2 ☐ No
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy
4 ☐ Pregnant at time of death 5 ☐ Other (specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☒ Probably 4 ☐ Unknown24a. Was an
autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings available
prior to completion of cause of
death?1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation
6 ☐ Could not be determined28a. Date of Injury
(Month, Day Year)28b. Time of
Injury28c. Injury at
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
and manner stated.

29b. Signature and title of certifier

Benjamin M. Spiller MD

29c. License number

D28281

29d. Date signed (Month, Day, Year)

JANUARY 26, 2004

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

NELSON BENTERS M.D., 9131 PISCATAWAY ROAD, CLINTON, MD 20735

31. Date filed (Month, Day, Year)

JAN 28 2004

32. Registrar's Signature

Benjamin M. Spiller

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show
any injury or other traumatic event, the Medical Examiner must be notified at
once.Physician
/Medical
ExaminerTo the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar Amend Item #28a-fperMEOG828 2/9/04 Certificate of Death

Reg. No. 2004 03593

Physician
/Medical
ExaminerFuneral
Director

1. Decedent's Name (First, Middle, Last) Gary D. Billips				2. Date of Death Month January Day 11 Year 2004		3. Time of Death 11:15 A M	
4a. Facility Name (If not institution, give street and number) 5271 Pulaski Highway				4b. City, Town, or Location of Death Perryville		4c. County of Death Cecil	
5. Social Security Number 221-42-4315		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 48 Yrs.		8. Date of Birth (Month, Day, Year) July 15, 1955	
9. Birthplace (State or Foreign Country) Delaware							
Usual Residence of Decedent							
10a. State Delaware		10b. County New Castle		10c. City, Town or Location Wilmington		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
10e. Street and Number 2117 Faulkland Road				10f. Zip Code 19805		10g. Citizen of What Country? U.S.A.	
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) Twelve Years				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Salesman		16b. Kind of Business/Industry Automobile Industry	
17. Father's Name (First, Middle, Last) Roy Billips				18. Mother's Name (First, Middle, Maiden Surname) June Bowman			
19a. Informant's Name/Relationship (Type, Print) Tandra Crescenzi				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2117 Faulkland Road, Wilmington, Delaware 19805			
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Hockessin Crematory		Date 01/21/04		20c. Location - City or Town, State Hockessin, Delaware	
21. Signature of Funeral Service Licensee <i>Thomas H. Patterson Jr.</i>				22. Name and Address of Facility Lee A. Patterson & Son Funeral Home, P.A. Perryville, Maryland 21903-0766			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) hanging a. Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Approximate Interval Between Onset and Death immediate							
23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown							
23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <input type="checkbox"/> Unknown							
23d. Date of delivery Month Day Year							
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown							
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No							
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No							
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> OOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) Motel Room					
27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year) Found 1-11-04		28b. Time of Injury Unknown M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
28d. Describe how injury occurred Hanged Self		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Motel					
28f. Location (Street and Number or Rural Route Number, City or Town, State) 5271 Pulaski Hwy Perryville, MD							
29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.							
29b. Signature and title of certifier <i>H. Farkas, MD</i>				29c. License number D15314		29d. Date signed (Month, Day, Year) January 12, 2004	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) H. Farkas, MD Union Hospital, Elkton, MD 21921							
31. Date filed (Month, Day, Year) JAN 15 2004				32. Registrar's Signature <i>[Signature]</i>			

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

ORIGINAL

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene
Certificate of Death

Reg. No.

2004 03594

1- For
State
RegistrarPhysician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Virginia Dare Brown

2. Date of Death

Month Day Year
January 7, 2004

3. Time of Death

10:10 AM

4a. Facility Name (If not institution, give street and number)

Regency Park Assisted Living

4b. City, Town, or Location of Death

Gambrills

4c. County of Death

Anne Arundel Co.

Funeral
Director

5. Social Security Number

578-20-7761

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

84

Yrs.

If Under 1 Year

Months

If Under 24 Hrs.

Days Hours Min.

8. Date of Birth

(Month, Day, Year)

Sept. 15, 1919

9. Birthplace (State or Foreign Country)

North Carolina

Usual Residence of Decedent

10a. State

MD

10b. County

Calvert Co.

10c. City, Town or Location

Chesapeake Beach

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

4001 Band Shell Court

10f. Zip Code

20732

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: White

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4or 5+)

12

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Telephone Operator

16b. Kind of Business/Industry

Federal Government

17. Father's Name (First, Middle, Last)

Joseph Milton Henry

18. Mother's Name (First, Middle, Maiden Surname)

Lena Mae Daughtry

19a. Informant's Name/Relationship (Type, Print)

Karlene V. Rosasco (Daughter)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

4001 Band Shell Ct., Chesapeake Beach, MD 20732

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Arlington National Cem.

Date

January 26, 2004

20c. Location - City or Town, State

Arlington, Virginia

21. Signature of Funeral Service Licensee

Michael W. Lee

22. Name and Address of Facility Lee Funeral Home Calvert, P.A.

3125 Southern Maryland Blvd., Owings, MD 20736

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

a. Congestive Heart Failure

Due to (or as a consequence of):

b. Coronary Artery Disease

Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate
Interval Between
Onset and Death

1 month

5 years

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

IF FEMALE:

23b. Was decedent pregnant
in the past 12 months?1 ☐ Yes 2 ☒ No
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy
4 ☐ Pregnant at time of death 5 ☐ Other (Specify)
9 ☐ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an
autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings available
prior to completion of cause of
death?1 ☐ Yes 2 ☒ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural 5 ☐ Pending
investigation
2 ☐ Accident 6 ☐ Could not be
determined
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury

(Month, Day, Year)

28b. Time of
Injury

M

28c. Injury at
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
and manner stated.

29b. Signature and title of certifier

Elliott Gorbach MD

29c. License number

D 20094

29d. Date signed (Month, Day, Year)

01/09/04

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Elliott Gorbach MD, 1411 Madison Park Drive, Glen Burnie, MD, 21061

31. Date filed (Month, Day, Year)

JAN 09 2004

32. Registrar's Signature

James H. Spiller

State
Registrar

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show
any injury or other traumatic event, the Medical Examiner must be notified at
once.To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2004 03595

1- For
State
RegistrarPhysician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Herbert Lee Byrd

2. Date of Death

January 18, 2004

3. Time of Death

8:30 p M

Funeral
Director

4a. Facility Name (If not institution, give street and number)

7808 Lakeshore Drive

4b. City, Town, or Location of Death

Owings

4c. County of Death

Calvert

5. Social Security Number

579-09-8952

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

83 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Aug. 27, 1920

9. Birthplace (State or Foreign Country)

Tennessee

Usual Residence of Decedent

10a. State

Maryland

10b. County

Calvert

10c. City, Town or Location

Owings

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

7808 Lakeshore Drive

10f. Zip Code

20736

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☒ Yes 2 ☐ No
If Yes, Give Year or Dates: 1942-45

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: white

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

metal lather

16b. Kind of Business/Industry

construction

17. Father's Name (First, Middle, Last)

Lee M. Byrd

18. Mother's Name (First, Middle, Maiden Surname)

Edith Gray

19a. Informant's Name/Relationship (Type, Print)

Rose A. Byrd, wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

7808 Lakeshore Dr., Owings, MD 20736

20a. Method of Disposition

1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☒ Other (Specify)

entombment

20b. Place of Disposition (Name of cemetery, crematory or other place)

Resurrection Cemetery

Date

1/22/2004

20c. Location - City or Town, State

Clinton, MD

21. Signature of Funeral Service Licensee

William R. Ye

22. Name and Address of Facility

Rausch Funeral Home, P.A., Owings, MD 20736

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. ASPIRATION PNEUMONIA

Due to (or as a consequence of):

b. CHRONIC OBSTRUCTIVE PULMONARY DISEASE

Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No
9 ☐ Unknown23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 5 ☐ Ectopic pregnancy
9 ☐ Unknown23d. Date of delivery
Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

STROKE

Asbestosis

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☒ Probably 4 ☐ Unknown24a. Was an autopsy performed?
1 ☐ Yes 2 ☒ No24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No25. Was case referred to medical examiner?
1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☒ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation
2 ☐ Accident 6 ☐ Could not be determined
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Peter L. Wisniewski

29c. License number

D40370

29d. Date signed (Month, Day, Year)

1/20/04

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Peter L. Wisniewski, M.D. 110 Hospital Rd. #310, Prince Frederick, MD 20678

31. Date filed (Month, Day, Year)

JAN 21 2004

32. Registrar's Signature

Bryan H. Smith

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or item 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.Physician
/Medical
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

15+1

State
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2004 03596

1- For State Registrar

RONALD F. CASTANEDA 219-48-8927

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) RONALD F. CASTANEDA				2. Date of Death Month Day Year January 19 2004		3. Time of Death 0040 M	
	4a. Facility Name (If not institution, give street and number) Peninsula Regional Medical Center				4b. City, Town, or Location of Death Salisbury		4c. County of Death Wicomico	
Funeral Director	5. Social Security Number 219-48-8927		6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		7. Age (In yrs. last birthday) 58 Yrs.		8. Date of Birth (Month, Day, Year) 8/28/1945	
	9. Birthplace (State or Foreign Country) Kansas		10a. State MD		10b. County Worcester		10c. City, Town or Location Pocomoke City	
10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		10e. Street and Number 414 Cedar Street		10f. Zip Code 21851		10g. Citizen of What Country? USA		
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates: Army		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4or 5+) 4		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Engineer		16b. Kind of Business/Industry Government				
17. Father's Name (First, Middle, Last) Frank Castaneda				18. Mother's Name (First, Middle, Maiden Surname) Phyllis Hamby				
19a. Informant's Name/Relationship (Type, Print) Gina Hutchinson/Daughter				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 23442 10354 Jerusalem Rd., Temperanceville, VA				
20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Salisbury Crematory		20c. Location - City or Town, State 1/21/04 Salisbury, MD				
21. Signature of Funeral Service Licensee Michael A. Dean		22. Name and Address of Facility Holloway Melson Funeral Home, P.A. 103 Linden Ave., Pocomoke City, MD 21851						
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Massive Pulmonary Emboli Due to (or as a consequence of): b. Sepsis Due to (or as a consequence of): c. Congestive Heart Failure Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last								
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (Specify) 9 <input type="checkbox"/> Unknown		23d. Date of delivery Month Day Year				
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown		
24a. Was an autopsy performed? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No						
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)						
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		
28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.								
29b. Signature and title of certifier Joseph P. Patin, M.D.		29c. License number D59568		29d. Date signed (Month, Day, Year) 1-19-2004				
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Joseph Patin, M.D. 100 E CARROLL ST. SALISBURY MD 21801								
31. Date filed (Month, Day, Year) JAN 22 2004		32. Registrar's Signature Keren H. Harris						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2004 03597

Certificate of Death

Reg. No.

1- For
State
Registrar

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Physician
/Medical
ExaminerFuneral
Director

1. Decedent's Name (First, Middle, Last) William FRANCIS		2. Date of Death Month January Day 21 Year 2004		3. Time of Death 17:35 M	
4a. Facility Name (If not institution, give street and number) Johns Hopkins Hospital		4b. City, Town, or Location of Death Baltimore		4c. County of Death	
5. Social Security Number 216-76-7981		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 41 Yrs.	
8. Date of Birth (Month, Day, Year) Aug. 1, 1962		9. Birthplace (State or Foreign Country) Washington, D.C.			
Usual Residence of Decedent					
10a. State MD		10b. County Calvert		10c. City, Town or Location Lusby	
10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
10e. Street and Number 7850 Pine Blvd.		10f. Zip Code 20657		10g. Citizen of What Country? United States	
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:	
14. Race - American Indian, Black, White, etc. Specify: White					
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4or 5+) -		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Iron Worker		16b. Kind of Business/Industry Vault Construction	
17. Father's Name (First, Middle, Last) Louis Copsey		18. Mother's Name (First, Middle, Maiden Surname) Evelyn Cochran			
19a. Informant's Name/Relationship (Type, Print) Laurie J. Copsey (WIFE)		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7850 Pine Blvd. Lusby, Maryland 20657			
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Mt. Harmony U.M.C. Cem. Jan. 26, 2004 Owings, MD		20c. Location - City or Town, State	
21. Signature of Funeral Service Licensee [Signature] MO 1095		22. Name and Address of Facility Rausch Funeral Home, P.A. 4405 Broomes Island Rd. Port Republic, MD 20676			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.					
Immediate Cause (Final disease or condition resulting in death)					
a. Deposits					
Due to (or as a consequence of):					
b. Pneumocystis pneumonia					
Due to (or as a consequence of):					
c. Mycobacteria					
Due to (or as a consequence of):					
d. Aspergillus					
Approximate Interval Between Onset and Death 2 weeks					
3 weeks					
3 weeks					
3 weeks					
23b. IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown					
23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <input type="checkbox"/> Unknown					
23d. Date of delivery Month Day Year					
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Liver failure, Renal transplant secondary to Renal failure					
23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown					
24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No					
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined					
28a. Date of Injury (Month, Day Year)					
28b. Time of Injury M					
28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
28d. Describe how injury occurred					
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)					
28f. Location (Street and Number or Rural Route Number, City or Town, State)					
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.					
29b. Signature and title of certifier [Signature] MD					
29c. License number RES-000					
29d. Date signed (Month, Day, Year) January 21, 2004					
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Christopher Gerald Williams 600 North Wolfe Street Baltimore MD 21287-9106					
31. Date filed (Month, Day, Year) JAN 28 2004					
32. Registrar's Signature [Signature]					

State
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2004 03598

1- For
State
RegistrarPhysician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Amelia Baer Cressman

2. Date of Death

January 17, 2004

3. Time of Death

1:50 A^MFuneral
Director

4a. Facility Name (If not institution, give street and number)

Gilchrist Hospice

4b. City, Town, or Location of Death

Towson

4c. County of Death

Baltimore

5. Social Security Number

171-05-1003

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

85 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

May 22, 1918

9. Birthplace (State or Foreign Country)

Pennsylvania

Usual Residence of Decedent

10a. State

Maryland

10b. County

Howard

10c. City, Town or Location

Ellicott City

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

3165 Sonia Trail

10f. Zip Code

21043

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.Specify:
White

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working
life. DO NOT use retired)

Resident Manager

16b. Kind of Business/Industry

Real Estate

17. Father's Name (First, Middle, Last)

Kurt Paul Baer

18. Mother's Name (First, Middle, Maiden Surname)

Elizabeth Knapp

19a. Informant's Name/Relationship (Type, Print)

Khristine C. Leach/granddaughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

3165 Sonia Trail Ellicott City, MD 21043

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Bayview Crematory

Date

January 19, 2004

20c. Location - City or Town, State

Baltimore, Maryland

21. Signature of Funeral Service Licensee

Beverly L. Heckrotte - MO1251

22. Name and Address of Facility

Going Home Cremation Service P.O. Box 784
Beverly L. Heckrotte, P.A. Clarksville, MD 2102923a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)a. Dementia
Due to (or as a consequence of):Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Lastb. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d.Approximate
Interval Between
Onset and Death

years

IF FEMALE:

23b. Was decedent pregnant
in the past 12 months?
1 ☐ Yes 2 ☒ No
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy
4 ☐ Pregnant at time of death 5 ☐ Other (specify)
9 ☐ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an
autopsy
performed?
1 ☐ Yes 2 ☒ No24b. Were autopsy findings available
prior to completion of cause of
death?
1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?
1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☒ Residence6 ☐ Other (Specify) Hospice

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation
2 ☐ Accident 6 ☐ Could not be determined
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury

(Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Beverly L. Heckrotte

29c. License number

D 58303

29d. Date signed (Month, Day, Year)

JANUARY 17 2004

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Armed Charles, MD 6601 N. Charles St Baltimore MD 21204

31. Date filed (Month, Day, Year)

JAN 21 2004

32. Registrar's Signature

Steven H. Sparks

State
Registrar

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "Natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To Be Completed by Funeral Director

Medical Certification; To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2004 03599

1- For
State
Registrar

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Pauline Elizabeth Denton		2. Date of Death Month: Jan 12 2004 Day: Year		3. Time of Death 4 25 A M	
	4a. Facility Name (If not institution, give street and number) Calvert Memorial Hospital		4b. City, Town, or Location of Death Prince Frederick		4c. County of Death Calvert	
Funeral Director	5. Social Security Number 214 22 6544	6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 79 Yrs.	8. Date of Birth Month: Oct 26 1924 Day: Year	9. Birthplace (State or Foreign Country) South Carolina	
	Usual Residence of Decedent					
To Be Completed by Funeral Director	10a. State Maryland	10b. County Calvert	10c. City, Town or Location Prince Frederick		10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
	10e. Street and Number 365 Gott Road		10f. Zip Code 20678		10g. Citizen of What Country? United States	
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:	
	14. Race - American Indian, Black, White, etc. Specify: white		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 4			
	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Registered Nurse		16b. Kind of Business/Industry health care			
	17. Father's Name (First, Middle, Last) Harold Brigham		18. Mother's Name (First, Middle, Maiden Surname) Laura Daniel			
	19a. Informant's Name/Relationship (Type, Print) Joseph L. Denton, Sr. - husband		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 365 Gott Rd. Prince Frederick, MD 20678			
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Central Cemetery Jan 14, 2004		20c. Location - City or Town, State Barstow Maryland	
	21. Signature of Funeral Service Licensee B. Rausch		22. Name and Address of Facility Rausch Funeral Home PA 4405 Brookes Is. rd. Fort Republic MD 20676			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. PNEUMONIA Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Approximate Interval Between Onset and Death 1 Week					
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown 23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) 9 <input type="checkbox"/> Unknown 23d. Date of delivery Month: Day: Year:						
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. CHRONIC CORONARY FAILURE, PERIPHERAL VASCULAR DISEASE, CORONARY ARTERY DISEASE, HYPERTENSION, DIABETES MELLITUS						
23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown						
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No						
24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No						
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No						
26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)						
27. Manner of Death 1 <input type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined						
28a. Date of Injury (Month, Day Year) 28b. Time of Injury M 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 28d. Describe how injury occurred 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)						
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.						
29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) JAN. 12. 2004						
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) JOHN WILSON Prince Frederick MD - 20678						
31. Date filed (Month, Day, Year) JAN 13 2004 32. Registrar's Signature K. H. Speaks						

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit once.

Physician
/Medical
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

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12

State
Registrar

VOID

CERTIFICATE #

2004 - 03600

SEE

CERTIFICATE #

2004 - fetal
00585

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death WCHD

Reg. No.

2004 03601

Amended

1- For State Registrar item #5 1/28/2004, E.T.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Marie Elizabeth Disbrow				2. Date of Death Month 01 Day 24 Year 2004				3. Time of Death 2:45AM			
	4a. Facility Name (If not institution, give street and number) 157 Oyster Lane				4b. City, Town, or Location of Death Ocean City				4c. County of Death Worcester			
Funeral Director	5. Social Security Number 334-33-1432		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 63 Yrs.		8. Date of Birth (Month, Day, Year) 09/19/1940		9. Birthplace (State or Foreign Country) Illinois			
	10a. State MD				10b. County Worcester		10c. City, Town or Location Ocean City				10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No	
To Be Completed by Funeral Director	10e. Street and Number 157 Oyster Lane				10f. Zip Code 21842				10g. Citizen of What Country? USA			
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: White			
To Be Completed by Physician/Medical Examiner	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 2				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Teller				16b. Kind of Business/Industry Bank			
	17. Father's Name (First, Middle, Last) Marvin Hurley				18. Mother's Name (First, Middle, Maiden Surname) Martha Schmitt							
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) Warren Disbrow (husband)				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 157 Oyster Lane Ocean City, MD 21842							
	20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Cape Henlopen Crem.				20c. Location - City or Town, State 01/28/2004 Frankford, DE			
To Be Completed by Physician/Medical Examiner	21. Signature of Funeral Service Licensee <i>Therese J. Pappalardo</i>				22. Name and Address of Facility The Burbage Funeral Home 108 William Street Berlin, MD 21811							
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or head failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. metastatic OVARIAN CARCINOMA Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of):				Approximate Interval Between Onset and Death 5 years							
To Be Completed by Physician/Medical Examiner	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 9 <input type="checkbox"/> Unknown				23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) 9 <input type="checkbox"/> Unknown				23d. Date of delivery Month Day Year			
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown							
To Be Completed by Physician/Medical Examiner	24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No							
	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)							
To Be Completed by Physician/Medical Examiner	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide				28a. Date of Injury (Month, Day Year)				28b. Time of Injury M 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No			
	28c. Injury at Work?				28d. Describe how injury occurred							
To Be Completed by Physician/Medical Examiner	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)							
	29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				29b. Signature and title of certifier <i>Adam W. Elks MD</i>				29c. License number D0056992			
To Be Completed by Physician/Medical Examiner	29d. Date signed (Month, Day, Year) 1/27/04				30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ADAM W. ELKS, MD 29 Broad Street Berlin, MD 21811							
	31. Date filed (Month, Day, Year) JAN 27 2004				32. Registrar's Signature <i>James H. Sparks</i>							

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

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To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

E 8

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

1- For State Registrar

2004 03602

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) David Evans		2. Date of Death Month January Day 10 , Year 2004		3. Time of Death 9:54 P M
	4a. Facility Name (If not institution, give street and number) Mariner Health of Southern Maryland		4b. City, Town, or Location of Death Clinton		4c. County of Death Prince Georges
Funeral Director	5. Social Security Number 416-40-6358	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 73 Yrs.	8. Date of Birth (Month, Day, Year) November 19, 1930	9. Birthplace (State or Foreign Country) Alabama
	Usual Residence of Decedent				
To Be Completed by Funeral Director	10a. State Maryland	10b. County Prince Georges	10c. City, Town or Location Clinton		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
	10e. Street and Number 8600 Mike Shapiro Drive #115		10f. Zip Code 20735		10g. Citizen of What Country? USA
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: 1955-1957		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:
	14. Race - American Indian, Black, White, etc. Specify: Black		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4or 5+) College		
	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Equipment Operator		16b. Kind of Business/Industry Federal Government		
	17. Father's Name (First, Middle, Last) Allen Evans		18. Mother's Name (First, Middle, Maiden Surname) Mattie Day		
	19a. Informant's Name/Relationship (Type, Print) Alice Evans/Wife		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8600 Mike Shapiro Dr. #115 Clinton, Maryland 20735		
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) MD Veterans Cemetery		Date 1/20/04
	20c. Location - City or Town, State Cheltenham, Maryland		21. Signature of Funeral Service Licensee Odessa Ofter		
	22. Name and Address of Facility Adams Funeral Home P.A. Aquasco, Maryland		22. License Number MO1323		
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Cardio Respiratory Arrest Due to (or as a consequence of): Coronary Artery Disease Due to (or as a consequence of): Hypertension Due to (or as a consequence of): Hyperlipidemia				Approximate Interval Between Onset and Death
	23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Other (specify)
	23d. Date of delivery Month Day Year				
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Status Post CVA Obesity Dementia, Feeding Dysfunction				
	24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M
	28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred		
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)		
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				29b. Signature and title of certifier Robert S. Castrence M.D.
29c. License number DC 5078				29d. Date signed (Month, Day, Year) 1/13/04	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Robert S. Castrence, M.D. 4302 St. Barnabas Rd Ste B Temple Hills, MD 20748					
31. Date filed (Month, Day, Year) JAN 27 2004					
32. Registrar's Signature [Signature]					

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2004 03603

1- For
State
RegistrarPhysician
/Medical
ExaminerFuneral
Director

1. Decedent's Name (First, Middle, Last)

JOHN LAWRENCE GIBSON

2. Date of Death

JANUARY 31 2004

3. Time of Death

6:50 A M

4a. Facility Name (If not institution, give street and number)

Frederick Memorial Hospital

4b. City, Town, or Location of Death

Frederick

4c. County of Death

Frederick

5. Social Security Number

220-38-4022

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

61 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

May 30, 1942

9. Birthplace (State or Foreign Country)

West Virginia

Usual Residence of Decedent

10a. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Kensington

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

4119 Warner Street

10f. Zip Code

20895

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: White

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Master Mechanic

16b. Kind of Business/Industry

Automotive Dealership

17. Father's Name (First, Middle, Last)

French Gibson

18. Mother's Name (First, Middle, Maiden Surname)

Barbara Jean House

19a. Informant's Name/Relationship (Type, Print)

Nancy J. Gibson, wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

4119 Wamer Street, Kensington, Maryland 20895

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Smithsburg Crematory

Date

2/3/2004

20c. Location - City or Town, State

Smithsburg, Maryland

21. Signature of Funeral Service Licensee

Kyan M. Bager M00999

22. Name and Address of Facility

Keeney and Basford Funeral Home
106 East Church Street, Frederick, MD 2170123a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)a. Coronary vascular accident

Due to (or as a consequence of):

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate
Interval Between
Onset and Death
15 days

IF FEMALE:

23b. Was decedent pregnant
in the past 12 months?1 ☐ Yes 2 ☐ No
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy
4 ☐ Pregnant at time of death 5 ☐ Other (specify)
9 ☐ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an
autopsy
performed?
1 ☐ Yes 2 ☒ No24b. Were autopsy findings available
prior to completion of cause of
death?
1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?
1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending
investigation
2 ☐ Accident 6 ☐ Could not be
determined
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury

(Month, Day Year)

28b. Time of
Injury

M

28c. Injury at
Work?1 ☐ Yes 2 ☐ No28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
and manner stated.

29b. Signature and title of certifier

Kyan M. Bager MD

29c. License number

D003105D

29d. Date signed (Month, Day, Year)

2-3-04

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Gene Howard, 10200 Poppermint Rd, Woodbury MD 21798

31. Date filed (Month, Day, Year)

FEB - 9 2004

32. Registrar's Signature

Kyan M. Bager

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show
any injury or other traumatic event, the Medical Examiner must be notified at
once.Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2004 03604

1- For State Registrar

Physician /Medical Examiner

Funeral Director

1. Decedent's Name (First, Middle, Last) Jason Daniel Gearing			2. Date of Death Month JANUARY Day 10 Year 2004		3. Time of Death 0821 A M	
4a. Facility Name (If not institution, give street and number) 2001 DARES BEACH ROAD			4b. City, Town, or Location of Death PRINCE FREDERICK		4c. County of Death CALVERT	
5. Social Security Number 216-21-3171		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 22 Yrs.		8. Date of Birth (Month, Day, Year) August 6 1981	
9. Birthplace (State or Foreign Country) Washington, DC		Usual Residence of Decedent				
10a. State MD		10b. County Calvert		10c. City, Town or Location Prince Frederick		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
10e. Street and Number 2001 Dares Beach Road			10f. Zip Code 20678		10g. Citizen of What Country? USA	
11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4or 5+)			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Cook		16b. Kind of Business/Industry Resturant	
17. Father's Name (First, Middle, Last) Ernest Michener Gearing			18. Mother's Name (First, Middle, Maiden Surname) Patricia A. Seabolt			
19a. Informant's Name/Relationship (Type, Print) James F. Cornette, Sr (Step-Father)			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2001 Dares Beach Road Prince Frederick, MD 20678			
20a. Method of Disposition <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input checked="" type="checkbox"/> Other (Specify) Entomb		20b. Place of Disposition (Name of cemetery, crematory or other place) Resurrection Cem.		20c. Location - City or Town, State Clinton, MD		20d. Date January 16 2004
21. Signature of Funeral Service Licensee Gary J. Goff			22. Name and Address of Facility Lee Funeral Home Calvert, PA 8125 Southern Maryland Blvd. Owings, MD 20736			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) intracranial shotgun wound Due to (or as a consequence of): a. _____ b. _____ c. _____ d. _____ Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last						Approximate Interval Between Onset and Death
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Unknown <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Other (specify)		23d. Date of delivery Month _____ Day _____ Year _____		
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						
23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown						
24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		24c. _____		
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) AT SCENE				
27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year) 1-10-04		28b. Time of Injury 8:15 A M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
28d. Describe how injury occurred Subject shot self		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) at home		28f. Location (Street and Number or Rural Route Number, City or Town, State) 2001 Dares Beach Road Prince Frederick MD		
29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.						
29b. Signature and title of certifier Patricia Aronica-Polkus		29c. License number OCME		29d. Date signed (Month, Day, Year) JANUARY 11, 2004		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) PATRICIA ARONICA-POLKUS 111 Penn Street, Baltimore, Maryland 21201						
31. Date filed (Month, Day, Year) JAN 15 2004		32. Registrar's Signature Jason D. Gearing				

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2004 03605

1- For
State
RegistrarPhysician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

PAULINE RUTH HOWARD

2. Date of Death

Month Day Year
01 14 2004

3. Time of Death

14:24p M

Funeral
Director

4a. Facility Name (If not institution, give street and number)

Hartley Hall Nursing Home

4b. City, Town, or Location of Death

Pocomoke City

4c. County of Death

Worcester

5. Social Security Number

218-20-6119

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

88 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
01/25/1915

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

MD

10b. County

Worcester

10c. City, Town or Location

Pocomoke City

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

1006 Market Street

10f. Zip Code

21851

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

11

College (1-4or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Caregiver

16b. Kind of Business/Industry

Healthcare

17. Father's Name (First, Middle, Last)

Edward Colonna

18. Mother's Name (First, Middle, Maiden Surname)

Eva Tull

19a. Informant's Name/Relationship (Type, Print)

Patricia DiMattia (daughter)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

409 Linden Ave., Apt. 102, Pocomoke City, MD 21851

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

First Baptist Cemetery

Date

1/17/2004

20c. Location - City or Town, State

Pocomoke City, MD

21. Signature of Funeral Service Licensee

Michael A. Dean

22. Name and Address of Facility

Holloway Nelson Funeral Home, P.A.
103 Linden Ave., Pocomoke City, MD 21851

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Dementia

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetus death 3 ☐ Ectopic pregnancy
4 ☐ Pregnant at time of death 5 ☐ Other (specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

C. V. A.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy performed?
1 ☐ Yes 2 ☒ No24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No25. Was case referred to medical examiner?
1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ OOA

26. Place of Death (Check only one)

Other: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Barclay M.D.

29c. License number

D-54422

29d. Date signed (Month, Day, Year)

1-14-04

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1604 Market St, Pocomoke, MD 21851

31. Date filed (Month, Day, Year)

JAN 22 2004

32. Registrar's Signature

Karen B. Sparks

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

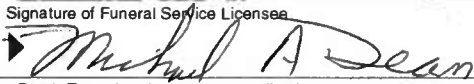
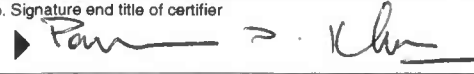
State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2004 03606

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) FERN KATHRYN BAKER HOSTETLER						2. Date of Death Month Day Year 01 16 2004		3. Time of Death 11:25 pm	
	4a. Facility Name (If not institution, give street and number) 7201 Mennonite Church Road						4b. City, Town, or Location of Death Westover		4c. County of Death Somerset	
Funeral Director	5. Social Security Number 219-34-3262		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 66 Yrs.		8. Date of Birth (Month, Day, Year) 9/16/1937		9. Birthplace (State or Foreign Country) Maryland	
	Usual Residence of Decedent									
10a. State MD		10b. County Somerset		10c. City, Town or Location Westover				10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
10e. Street and Number 7201 Mennonite Church Road						10f. Zip Code 21871		10g. Citizen of What Country? USA		
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: white		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker				16b. Kind of Business/Industry Domestic		
17. Father's Name (First, Middle, Last) Melvin Baker						18. Mother's Name (First, Middle, Maiden Surname) Minnie Yoder				
19a. Informant's Name/Relationship (Type, Print) Norman L. Hostetler (husband)						19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7201 Mennonite Church Rd., Westover, MD 21871				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Holly Grove Mennonite Cemetery		Date 1/21/2004		20c. Location - City or Town, State Westover, MD		
21. Signature of Funeral Service Licensee 						22. Name and Address of Facility Holloway Nelson Funeral Home, P.A. 103 Linden Ave., Pocomoke City, MD 21851				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Metastatic Renal cell Carcinoma Due to (or as a consequence of): Sequitely list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of):										Approximate Interval Between Onset and Death 5 mo.
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		
								24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
								24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred		
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)						
29a. Certifier <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.										
29b. Signature and title of certifier 						29c. License number 00014314		29d. Date signed (Month, Day, Year) 1/19/2004		
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) PANPIT P. KLUG, 145 E Carroll Street, Salisbury, MD 21804										
31. Date filed (Month, Day, Year) JAN 22 2004				32. Registrar's Signature 						

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

201. 4

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2004 03607

1- For
State
Registrar

Baltimore, Maryland 21215-0036

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Physician
/Medical
ExaminerFuneral
Director

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

1. Decedent's Name (First, Middle, Last) Hattie Elizabeth Hawes		2. Date of Death Month Day Year January 17 2004		3. Time of Death 3:00 A^M	
4a. Facility Name (If not institution, give street and number) 3251 St. Johns Lane		4b. City, Town, or Location of Death Ellicott City		4c. County of Death Howard	
5. Social Security Number 213 01 4956	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 88 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) Sept 8, 1915
9. Birthplace (State or Foreign Country) Maryland					
10a. State MD		10b. County Howard		10c. City, Town or Location Ellicott City	
10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
10e. Street and Number 3251 St. Johns Lane		10f. Zip Code 21042		10g. Citizen of What Country? United States	
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:	
14. Race - American Indian, Black, White, etc. Specify: White					
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker		16b. Kind of Business/Industry Own Home	
17. Father's Name (First, Middle, Last) George Cunningham Stump		18. Mother's Name (First, Middle, Maiden Surname) Cora Elizabeth unknown			
19a. Informant's Name/Relationship (Type, Print) Carlton W. Hawes Jr./Son		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3251 St. Johns Lane Ellicott City, MD 21042			
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Good Shepherd Cem.		20c. Location - City or Town, State 1-21-2004 Ellicott City, MD	
21. Signature of Funeral Service Licensee Shen Collins-Walker M01044		22. Name and Address of Facility Harry H. Witzke's Family FH Inc. 4112 Old Columbia Pike Ellicott City, MD 21043			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Ischaemic cardiomyopathy Due to (or as a consequence of): b. Hypertension, essential Due to (or as a consequence of): c. Due to (or as a consequence of): d. Approximate Interval Between Onset and Death 6 + years 20 + years					
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <input type="checkbox"/> Unknown		23d. Date of delivery Month Day Year	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. pulmonary emphysema		23e. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown			
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M	
28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred			
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier Dr. J. J. J. J.		29c. License number D 21928	
29d. Date signed (Month, Day, Year) January 19, 2004					
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3459 St Johns Ln EC MD 21042					
31. Date filed (Month, Day, Year) JAN 20 2004		32. Registrar's Signature Shen Collins-Walker			

(4) 02

State
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2004 03608

1- For
State
Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Dorothy Rebecca Harrod				2. Date of Death Month Day Year January 5, 2004		3. Time of Death 2:40 A M	
	4a. Facility Name (If not institution, give street and number) Solomons Nursing Center				4b. City, Town, or Location of Death Solomons		4c. County of Death Calvert	
Funeral Director	5. Social Security Number 219-42-4100		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 81 Yrs.		8. Date of Birth (Month, Day, Year) Mar. 16, 1922		9. Birthplace (State or Foreign Country) Maryland
	Usual Residence of Decedent							
10a. State Maryland		10b. County Calvert		10c. City, Town or Location Lusby			10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
10e. Street and Number 690 Sollers Wharf				10f. Zip Code 20657		10g. Citizen of What Country? USA		
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: Black	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 7 College (1-4 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Housewife		16b. Kind of Business/Industry Own Home		
17. Father's Name (First, Middle, Last) Jacob Coby				18. Mother's Name (First, Middle, Maiden Surname) Henrietta Brown				
19a. Informant's Name/Relationship (Type, Print) Hilton Harrod/Son				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) P.O. Box 515 Lusby, MD 20657				
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Ernestine Jones Cem.		20c. Location - City or Town, State Chesapeake Bch., MD		
21. Signature of Funeral Service Licensee Dorothy A. Sewell				22. Name and Address of Facility Sewell Funeral Home 1451 Dares Beach Rd. Prince Fred., MD 20678				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Cardiac Arrhythmia Due to (or as a consequence of): Atherosclerotic Cardio-Vascular disease Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):								Approximate Interval Between Onset and Death 10 minutes more than 2 years.
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 9 <input type="checkbox"/> Unknown				23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) 3 <input type="checkbox"/> Ectopic pregnancy 9 <input type="checkbox"/> Unknown				23d. Date of delivery Month Day Year
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Dementia Atrial Fibrillation						23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown		
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)				
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined				28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
28d. Describe how injury occurred				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)		
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				29b. Signature and title of certifier Gyan C. Surana		29c. License number D 50653		29d. Date signed (Month, Day, Year) 1-5-04
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 5851 Deale Churchton Road Deale MD 20751								
31. Date filed (Month, Day, Year) JAN 06 2004				32. Registrar's Signature Kenna H. Spiller				

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

State
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

1- For
State
Registrar

2004 03609

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Richard Edward Humphreys

2. Date of Death

Jan 11 2004 Year

3. Time of Death

1610P M

Funeral
Director

4a. Facility Name (If not institution, give street and number)

Calvert Memorial Hospital

4b. City, Town, or Location of Death

Prince Frederick

4c. County of Death

Calvert

5. Social Security Number

220 16 8183

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

75

Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

(Month, Day, Year)

April 10 1928

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Calvert

10c. City, Town or Location

Prince Frederick

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

870 Main Street

10f. Zip Code

20678

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: White

15. Decedent's Education
(Specify only highest grade completed)Elementary/Secondary (0-12)
12

College (1-4 or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

plumber/ supervisor

16b. Kind of Business/Industry

City of Annapolis
Utility Dept.

17. Father's Name (First, Middle, Last)

John E. Humphreys, Sr.

18. Mother's Name (First, Middle, Maiden Surname)

Catherine Joy

19a. Informant's Name/Relationship (Type, Print)

Aleta Wilde Humphreys- wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

870 Main St. Prince Frederick MD 20678

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

St. Paul U.M. Cemetery

Date

Jan 15 2004

20c. Location - City or Town, State

Lusby Maryland

21. Signature of Funeral Service Licensee

B Rausch

22. Name and Address of Facility

Rausch Funeral Home PA
4405 Broomes Is. Rd. Port Republic MD 2067623a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

a. Stroke

Due to (or as a consequence of):

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate
Interval Between
Onset and Death

IF FEMALE:

23b. Was decedent pregnant
in the past 12 months?1 ☐ Yes 2 ☒ No
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy
4 ☐ Pregnant at time of death 5 ☐ Other (specify)
9 ☐ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

carotid stenosis

23e. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown24a. Was an
autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings available
prior to completion of cause of
death?1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending
investigation
2 ☐ Accident 6 ☐ Could not be
determined
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
and manner stated.

29b. Signature and title of certifier

J. Gu

29c. License number

751949

29d. Date signed (Month, Day, Year)

1/12/04

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Ho Hospital Rd, Suite 30 Prince Frederick MD 20678

31. Date filed (Month, Day, Year)

JAN 13 2004

32. Registrar's Signature

Klaus B. Spiller

State
Registrar

Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2004 03610

1- For State Registrar Amend Item #22 per FHG 828 2/9/04 EW Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Upshur Henry, Jr.				2. Date of Death Month Day Year JAN 07 20 04				3. Time of Death 7:53 a M	
	4a. Facility Name (If not institution, give street and number) Berlin Nursing Home				4b. City, Town, or Location of Death Berlin				4c. County of Death Worcester	
Funeral Director	5. Social Security Number 220-26-3269		6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		7. Age (In yrs. last birthday) 75 Yrs.		8. Date of Birth (Month, Day, Year) June 16, 1928		9. Birthplace (State or Foreign Country) MD	
	Usual Residence of Decedent				10a. State MD		10b. County Worcester		10c. City, Town or Location Berlin	
To Be Completed by Funeral Director	10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No				10e. Street and Number 10413 Harrison Rd.				10f. Zip Code 21811	
	10g. Citizen of What Country? U.S.				11. Marital Status 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced				12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:	
	13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: Black				15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 8 College (1-4 or 5+)	
	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Waterman				16b. Kind of Business/Industry Fishing				17. Father's Name (First, Middle, Last) Upshur Henry, Sr.	
	18. Mother's Name (First, Middle, Maiden Surname) Edna Brittingham				19a. Informant's Name/Relationship (Type, Print) Patsy Bowen/niece				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10413 Harrison Rd., Berlin, MD 21811	
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) St. Paul's Cemetery				20c. Location - City or Town, State Berlin, MD 21811	
	21. Signature of Funeral Service Licensee				22. Name and Address of Facility Lewis N Watson Funeral Home 1618 West Rd Salisbury, Md 21801				23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. <i>Arteriosclerotic Cardiovascular Disease</i> Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	
	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown				23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) 9 <input type="checkbox"/> Unknown				23d. Date of delivery Month Day Year	
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Diabetes Mellitus Type II. Emphysema</i> <i>Coronary Artery Disease</i> <i>Essential Hypertension. Alzheimer Disease</i>				23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown				24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
	24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)	
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined				28a. Date of Injury (Month, Day Year) 28b. Time of Injury M 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No				28d. Describe how injury occurred		
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)				29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		
29b. Signature and title of certifier <i>Gregorio M. Bellosa M.D.</i>				29c. License number D 29505				29d. Date signed (Month, Day, Year) 01-07-2004		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) GREGORIO M. BELLOSO, M.D.; 5302 CHINABERRY DR., SALISBURY, MD 21801				31. Date filed (Month, Day, Year) JAN 12 2004				32. Registrar's Signature <i>Benita B Sparks</i>		

HENRY UPSHUR
Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification; To Be Completed by Physician/Medical Examiner

#72
WIC, CO.
Division of Vital Records, P.O. Box 68760,

State
Registrar

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2004 03611

1- For
State
RegistrarPhysician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Richard

Johnson

2. Date of Death

January 17, 2004

3. Time of Death

1900 M

Funeral
Director

4a. Facility Name (If not institution, give street and number)

Southern Maryland Hospital

4b. City, Town, or Location of Death

Clinton

4c. County of Death

Prince Georges

5. Social Security Number

220-34-3926

6. Sex

10 M 20 F

7. Age (In yrs. last birthday)

65 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min

8. Date of Birth

December 6, 1938

9. Birthplace (State or Foreign)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Prince Georges

10c. City, Town or Location

Upper Marlboro

10d. Inside City Limits

X Yes 2 No

10e. Street and Number

16601 Candy Hill Road

10f. Zip Code

20772

10g. Citizen of What Country?

USA

11. Marital Status

1 Never Married 2 Married

3 Widowed 4 Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 Yes 2 No

If Yes, Give Year or Dates:

1961

1963

13. Was Decedent of Hispanic Origin? (Specify Yes or No -

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 Yes 2 No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: Black

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working

life. DO NOT use retired)

Supervisor

16b. Kind of Business/Industry

Federal Government

17. Father's Name (First, Middle, Last)

Maurice

Johnson

18. Mother's Name (First, Middle, Maiden Surname)

Josephine

Galloway

19a. Informant's Name/Relationship (Type, Print)

Lynell Matthews/Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

16601 Candy Hill Rd Upper Marlboro, Maryland 20772

20a. Method of Disposition

1 Burial 2 Cremation 3 Removal from State

4 Donation 5 Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Resurrection Cem

Date

1/24/04

20c. Location - City or Town, State

Clinton, Maryland

21. Signature of Funeral Service Licensee

Adessa Offer

MO1323

22. Name and Address of Facility

Adams Funeral Home P.A. Aquasco, Maryland

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. *Cardiac Arrest*

Due to (or as a consequence of):

b. *Alcoholism*

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Approximate Interval Between Onset and Death

10 days

Yr

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No

9 Unknown

23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death

4 Pregnant at time of death

9 Unknown

3 Ectopic pregnancy

5 Other (specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Acute Renal Failure
Gonorrhea

23e. Did tobacco use contribute to the cause of death?

1 Yes 2 No 3 Probably 4 Unknown

24a. Was an autopsy performed?

1 Yes 2 No

24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No

25. Was case referred to medical examiner?

1 Yes 2 No

Hospital:

1 Inpatient 2 ER/Outpatient 3 DOA

Other:

4 Nursing Home 5 Residence 6 Other (Specify)

27. Manner of Death

1 Natural

2 Accident

3 Suicide

4 Homicide

5 Pending investigation

6 Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 Yes 2 No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Thomas L. Feldman MD

29c. License number

D001923

29d. Date signed (Month, Day, Year)

Jan. 18, 2004

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

T. Feldman MD Waldorf MD 20601

31. Date filed (Month, Day, Year)

JAN 27 2004

32. Registrar's Signature

Karen H. Spivey

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2004 03612

Physician
/Medical
Examiner

Funeral
Director

1. Decedent's Name (First, Middle, Last) Walter Franklin Jones, Jr.				2. Date of Death Month: January Day: 4 Year: 2004		3. Time of Death 5:04 AM	
4a. Facility Name (If not institution, give street and number) Mercy Hospital				4b. City, Town, or Location of Death Baltimore		4c. County of Death N/A	
5. Social Security Number 216-36-7346		6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		7. Age (In yrs. last birthday) 65 Yrs.		8. Date of Birth (Month, Day, Year) Mar. 27, 1938	
9. Birthplace (State or Foreign Country) Maryland		10a. State Maryland		10b. County Calvert		10c. City, Town or Location Huntingtown	
10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		10e. Street and Number 2079 Plum Point Road		10f. Zip Code 20639		10g. Citizen of What Country? USA	
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: Black	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12): 12 College (1-4 or 5+): 2		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Superintendent		16b. Kind of Business/Industry Excavating Co.			
17. Father's Name (First, Middle, Last) Walter Franklin Jones, Sr.				18. Mother's Name (First, Middle, Maiden Surname) Janie S. Jones			
19a. Informant's Name/Relationship (Type, Print) Joyce E. Rice/Sister				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) P.O. Box 193 Huntingtown, MD 20639			
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Young's Cemetery		Date 1/9/04		20c. Location - City or Town, State Huntingtown, MD	
21. Signature of Funeral Service Licensee Gladya A. Seneff		22. Name and Address of Facility Sewell Funeral Home 1451 Dares Beach Road Prince Frederick, MD 20678					

To Be Completed by Funeral Director

Physician
/Medical
Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.		Approximate Interval Between Onset and Death	
Immediate Cause (Final disease or condition resulting in death)		a. head and neck cancer	
Due to (or as a consequence of):			
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		b. Due to (or as a consequence of):	
		c. Due to (or as a consequence of):	
		d. Due to (or as a consequence of):	

Medical Certification: To Be Completed by Physician/Medical Examiner

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				23b. Did tobacco use contribute to the cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown			
				24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No	
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other (Specify) hospice					
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
		28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28d. Describe how injury occurred			
				28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.							
29b. Signature and title of certifier David R. Rosenberg				29c. License number D408541		29d. Date signed (Month, Day, Year) 1/5/2004	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) David R. Rosenberg 301 ST. PAUL PL. Baltimore MD 21202							
31. Date filed (Month, Day, Year) JAN 08 2004				32. Registrar's Signature Beverly H. Spauld			

State
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2004 03613

1- For
State
Registrar

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Physician
/Medical
ExaminerFuneral
Director

To Be Completed by Funeral Director

Medical Certification; To Be Completed by Physician/Medical Examiner

1. Decedent's Name (First, Middle, Last) Freida Elizabeth Jones		2. Date of Death Month January Day 10 , Year 2004		3. Time of Death 10:30A M	
4a. Facility Name (If not institution, give street and number) Calvert Memorial Hospital		4b. City, Town, or Location of Death Prince Frederick		4c. County of Death Calvert	
5. Social Security Number 214-34-4191	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 84 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) Oct. 12, 1919
9. Birthplace (State or Foreign Country) Maryland		Usual Residence of Decedent			
10a. State Maryland		10b. County Calvert		10c. City, Town or Location Huntingtown	
10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		10e. Street and Number 4470 Harvest Lane			
10f. Zip Code 20639		10g. Citizen of What Country? USA			
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:	
14. Race - American Indian, Black, White, etc. Specify: Black		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 8 College (1-4or 5+) Cook			
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)		16b. Kind of Business/Industry Restaurant			
17. Father's Name (First, Middle, Last) Marion Holland		18. Mother's Name (First, Middle, Maiden Sumame) Mable Scott			
19a. Informant's Name/Relationship (Type, Print) Gaines Jones/Son		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) P.O. Box 712 Prince Frederick, MD 20678			
20a. Method of Disposition <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Mt. Geth. Chr. Cem.		20c. Location - City or Town, State 1/17/2004 Huntingtown, MD	
21. Signature of Funeral Service Licensee Gladys A. Sewell		22. Name and Address of Facility Sewell Funeral Home 1451 Dares Beach Rd. Prince Fred., MD 20678			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Cardiac Arrhythmia Due to (or as a consequence of): b. Atherosclerotic Cardiovascular disease Due to (or as a consequence of): c. Due to (or as a consequence of): d.		Approximate Interval Between Onset and Death 10 minutes more than 2 years			
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <input type="checkbox"/> Unknown		23d. Date of delivery Month Day Year	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. End-stage Renal disease on Hemodialysis Coronary Artery disease & sepsis Hypertensive heart disease		24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M	
28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred			
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier Gyan C Surana		29c. License number D50653	
29d. Date signed (Month, Day, Year) 1-10-2004		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) GYAN C SURANA 5851- Deale Churchton Road, Deale MD. 20751			
31. Date filed (Month, Day, Year) JAN 13 2004		32. Registrar's Signature Beverly H. Spiller			

Certificate of Death

Reg. No.

2004 03614

1- For State Registrar

Physician /Medical Examiner

Funeral Director

1. Decedent's Name (First, Middle, Last) Carolyn Diane Jones		2. Date of Death Month Day Year January 21, 2004		3. Time of Death 7:05 P M	
4a. Facility Name (If not institution, give street and number) 6200 9th Street		4b. City, Town, or Location of Death Chesapeake Beach		4c. County of Death Calvert	
5. Social Security Number 217-46-7299		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 52 Yrs.	
8. Date of Birth (Month, Day, Year) July 24, 1951		9. Birthplace (State or Foreign Country) Maryland			
Usual Residence of Decedent					
10a. State Maryland		10b. County Calvert		10c. City, Town or Location Chesapeake Beach	
10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		10e. Street and Number 6200 9th Street		10f. Zip Code 20732	
10g. Citizen of What Country? USA		11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:	
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: Black			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Health Aide		16b. Kind of Business/Industry Nursing Center	
17. Father's Name (First, Middle, Last) Aaron Reed		18. Mother's Name (First, Middle, Maiden Surname) Ruth Rice			
19a. Informant's Name/Relationship (Type, Print) George Jones/Husband		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) P.O. Box 154 Huntingtown, MD 20639			
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Ernestine Jones Cem		20c. Location - City or Town, State Chesapeake Bch., MD	
21. Signature of Funeral Service Licensee Bladys A. Sewell		22. Name and Address of Facility Sewell Funeral Home 1451 Dares Beach Rd Prince Frederick, MD 20678			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Carcinoma of Colon Due to (or as a consequence of): b. with Metastases Due to (or as a consequence of): c. Due to (or as a consequence of): d.		Approximate Interval Between Onset and Death 2 yrs			
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 9 <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (Specify)		23d. Date of delivery Month Day Year	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.					
23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown					
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No					
24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No					
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M	
28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred			
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.					
29b. Signature and title of certifier AT Muna		29c. License number D 19427		29d. Date signed (Month, Day, Year) 1/23/04	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Anwar Mushi, M.D. Prince Frederick, MD 20678					
31. Date filed (Month, Day, Year) JAN 23 2004		32. Registrar's Signature James H. Spade			

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2004 03615

1- For State Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Robert Francis Kinter			2. Date of Death Month January Day 16 Year 2004		3. Time of Death 8:15 a M	
	4a. Facility Name (If not institution, give street and number) 12030 Century Manor Drive			4b. City, Town, or Location of Death Dunkirk		4c. County of Death Calvert	
Funeral Director	5. Social Security Number 159-16-1697	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 86 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) Dec 15, 1917	9. Birthplace (State or Foreign Country) Pennsylvania
	Usual Residence of Decedent						
10a. State MD		10b. County Calvert		10c. City, Town or Location Dunkirk		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
10e. Street and Number 12030 Century Manor Drive			10f. Zip Code 20754		10g. Citizen of What Country? USA		
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: 1943-53		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: white	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 2 College (1-4or 5+) 2			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) commercial district manager		16b. Kind of Business/Industry G.E. medical systems		
17. Father's Name (First, Middle, Last) Peter Watson Kinter				18. Mother's Name (First, Middle, Maiden Surname) Mary Olive Cost			
19a. Informant's Name/Relationship (Type, Print) Johanna T. Kinter, wife				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12030 Century Manor Drive, Dunkirk, MD 20754			
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) St. John Vianney Cem.		20c. Location - City or Town, State 01/20/2004 Prince Frederick, MD		
21. Signature of Funeral Service Licensee William R. [Signature]			22. Name and Address of Facility Rausch Funeral Home, P.A., Owings, MD 20736				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Pneumonia Due to (or as a consequence of): b. Chronic Obstructive Pulmonary Disease Due to (or as a consequence of): c. Due to (or as a consequence of): d.							Approximate Interval Between Onset and Death 2 days years
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown			23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Other (specify) <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Unknown			23d. Date of delivery Month Day Year	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Arteriosclerotic Cardiovascular Disease Arrhythmias - Atrial Fibrillation 1996 Papillary Cell Bladder Carcinoma						23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown	
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)				
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28d. Describe how injury occurred			
28f. Location (Street and Number or Rural Route Number, City or Town, State)				28e. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.							
29b. Signature and title of certifier Gerald P. Sterner MD			29c. License number D17245		29d. Date signed (Month, Day, Year) MD. January 16, 2004		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) GERALD P. STERNER MD. Calvert-Arundel Medical Grp., Owings MD							
31. Date filed (Month, Day, Year) JAN 20 2004			32. Registrar's Signature [Signature]				

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23e or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

10+1

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2004 03616

1- For
State
RegistrarPhysician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Steven Andrew Kepich

2. Date of Death

January 17, 2004

3. Time of Death

10:04 AM

Funeral
Director

4a. Facility Name (If not institution, give street and number)

Southern Maryland Hospital Center

4b. City, Town, or Location of Death

Clinton

4c. County of Death

Prince George's Co.

5. Social Security Number

219-64-5571

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

50

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Sept. 3, 1953

9. Birthplace (State or Foreign Country)

New Jersey

Usual Residence of Decedent

10a. State

MD

10b. County

Prince George's Co.

10c. City, Town or Location

Upper Marlboro

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

6506 Dublin Place

10f. Zip Code

20772

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☒ Never Married 2 ☐ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: White

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

HVAC Technician

16b. Kind of Business/Industry

Federal Government

17. Father's Name (First, Middle, Last)

Andrew Keppich, Sr.

18. Mother's Name (First, Middle, Maiden Surname)

Margarete Piechulla

19a. Informant's Name/Relationship (Type, Print)

Margarete R. Kepich (Mother)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

6506 Dublin Place, Upper Marlboro, MD 20772

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Southern Mem. Gardens

Date

January 22, 2004

20c. Location - City or Town, State

Dunkirk, Maryland

21. Signature of Funeral Service Licensee

Michael W. Lee

22. Name and Address of Facility

Lee Funeral Home Calvert, P.A.
5125 Southern Maryland Blvd., Owings, MD 2073623a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

a. Acute Myocardial Infarction

Due to (or as a consequence of):

b. Coronary Artery Disease

Due to (or as a consequence of):

c. Metastatic Lung Cancer

Due to (or as a consequence of):

d. INTRACEREBRAL HEMMORRHAGE

Approximate
Interval Between
Onset and Death

IF FEMALE:

23b. Was decedent pregnant
in the past 12 months?1 ☐ Yes 2 ☐ No
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown3 ☐ Ectopic pregnancy5 ☐ Other (specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

DIABETES

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an
autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings available
prior to completion of cause of
death?1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient2 ☒ ER/Outpatient3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending
investigation
2 ☐ Accident 6 ☐ Could not be
determined
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury

(Month, Day Year)

28b. Time of
Injury

M

28c. Injury at
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Terry A. Jodrie

29c. License number

D40324

29d. Date signed (Month, Day, Year)

JANUARY 17, 2004

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Terry A. Jodrie, M.D. 7503 Surratts Road, Clinton, Maryland 20735

31. Date filed (Month, Day, Year)

JAN 20 2004

32. Registrar's Signature

Jodrie

State
Registrar

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural," or items 23a or 28e-f show
any injury or other traumatic event, a Medical Examiner must be notified at
once.Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2004 03617

1- For
State
RegistrarPhysician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Michael Konik

2. Date of Death

Month Day Year
January 16th 2004

3. Time of Death

11:55 AM

4a. Facility Name (If not institution, give street and number)

University of Maryland Medical Center

4b. City, Town, or Location of Death

Baltimore, Maryland

4c. County of Death

None

Funeral
Director

5. Social Security Number

197 20 8901

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

74

Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

(Month, Day, Year)
Nov 26, 1929

9. Birthplace (State or Foreign Country)

Pennsylvania

Usual Residence of Decedent

10a. State

MD

10b. County

Carroll

10c. City, Town or Location

Sykesville

10d. Inside City Limits

☐ Yes ☒ No

10e. Street and Number

4305 Coolidge Court

10f. Zip Code

21784

10g. Citizen of What Country?

United States

11. Marital Status

☐ Never Married ☒ Married
☐ Widowed ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

☒ Yes ☐ No
If Yes, Give Year or Dates: Korea

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

☐ Yes ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)
12

College (1-4or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Cake Decorator

16b. Kind of Business/Industry

Giant Food

17. Father's Name (First, Middle, Last)

Michael Konik Sr.

18. Mother's Name (First, Middle, Maiden Surname)

Mary Beloski

19a. Informant's Name/Relationship (Type, Print)

Nancy Bobby/Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2088 Harvest Farm Road Eldersburg, MD 21784

20a. Method of Disposition

☒ Burial ☐ Cremation ☒ Removal from State
☐ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Mt. Macrina

Date

1-20-2004

20c. Location - City or Town, State

Uniontown, PA

21. Signature of Funeral Service Licensee

Shirley Collins-Witzke

M01044

22. Name and Address of Facility

Harry H. Witzke's Family FH Inc.
4112 Old Columbia Pike Ellicott City, MD 21043

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Acute Myelogenous Leukemia

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

3 weeks

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Bacteremia

Due to (or as a consequence of):

1 week

c. Respiratory Failure

Due to (or as a consequence of):

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?
☐ Yes ☒ No
☐ Unknown

23c. If yes, outcome of pregnancy

☐ Live birth ☐ Fetal death ☐ Ectopic pregnancy
☐ Pregnant at time of death ☐ Other (specify)
☐ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

☐ Yes ☒ No ☐ Probably ☐ Unknown24a. Was an autopsy performed?
☐ Yes ☒ No24b. Were autopsy findings available prior to completion of cause of death?
☐ Yes ☐ No25. Was case referred to medical examiner?
☐ Yes ☒ No

Hospital:

☒ Inpatient☐ ER/Outpatient☐ DOA

Other:

☐ Nursing Home ☐ Residence ☐ Other (Specify)

27. Manner of Death

☒ Natural ☐ Pending investigation
☐ Accident ☐ Could not be determined
☐ Suicide ☐ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

☐ Yes ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Brenda Kelly MD

29c. License number

#15261

29d. Date signed (Month, Day, Year)

01/16/2004

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

22 S. Greene St. Baltimore, MD 21201

31. Date filed (Month, Day, Year)

JAN 20 2004

32. Registrar's Signature

Shirley Collins-Witzke

State
Registrar

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2004 03618

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Patrick Joseph Kelly				2. Date of Death Month Day Year January 23, 2004		3. Time of Death 7:30 AM	
	4a. Facility Name (If not institution, give street and number) 2700 Stinnett Road				4b. City, Town, or Location of Death Huntingtown		4c. County of Death Calvert County	
Funeral Director	5. Social Security Number 213-38-4155		6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		7. Age (In yrs. last birthday) 65		8. Date of Birth (Month, Day, Year) March 3, 1938	
	9. Birthplace (State or Foreign Country) Washington, DC		10a. State MD		10b. County Calvert County		10c. City, Town or Location Huntingtown	
To Be Completed by Funeral Director	10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		10e. Street and Number 2700 Stinnett Road		10f. Zip Code 20639		10g. Citizen of What Country? U.S.A.	
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White	
To Be Completed by Physician/Medical Examiner	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 4		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) RealEstate/Realtor		16b. Kind of Business/Industry Self-Employed		17. Father's Name (First, Middle, Last) Edward B. Kelly	
	18. Mother's Name (First, Middle, Maiden Surname) Sadie Frances Hansbury		19a. Informant's Name/Relationship (Type, Print) Christopher B. Kelly (Son)		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2696 Stinnett Road, Huntingtown, MD 20639		20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)	
To Be Completed by Physician/Medical Examiner	20b. Place of Disposition (Name of cemetery, crematory or other place) Southern Mem. Gardens		20c. Location - City or Town, State Dunkirk, Maryland		21. Signature of Funeral Service Licensee Michael W. Lee		22. Name and Address of Facility Lee Funeral Home Calvert, P.A. 8125 Southern Maryland Blvd., Owings, MD 20736	
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Myocardial infarction Due to (or as a consequence of): Coronary artery disease 5 years Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		23b. Did tobacco use contribute to the cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown		24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		27. Manner of Death 1 <input type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year) 28b. Time of Injury M 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 28d. Describe how injury occurred	
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)		29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier 29c. License number 045435 29d. Date signed (Month, Day, Year) 11/25/04	
State Registrar	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Varkey Matthew, M.D. 2419 Solomons Is Rd. Huntingtown MD 20639		31. Date filed (Month, Day, Year) JAN 26 2004		32. Registrar's Signature [Signature]		10 + 1	

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend Item #19 Paper INF, Item #23 Paper PHYC828 2/8/04 EV
 For AMEND/26 Per HY. State of Maryland Department of Health and Mental Hygiene
 1- Registrar 1/15/04 CMH ACO HEALTH DEPT. Certificate of Death

Reg. No.

2004 03619

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Elmer C. Knox

2. Date of Death

Month Jan. Day 11, Year 2004

3. Time of Death

11:20 a^M

4a. Facility Name (If not institution, give street and number)

Anne Arundel Medical Center

4b. City, Town, or Location of Death

Annapolis

4c. County of Death

Anne Arundel

5. Social Security Number

218-34-0470

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

65 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Month Mar. Day 11, Year 1938

9. Birthplace (State or Foreign Country)

MD

Usual Residence of Decedent

10a. State

MD

10b. County

Anne Arundel

10c. City, Town or Location

Annapolis

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

969 Mt. Holly Drive

10f. Zip Code

21401

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☒ Yes 2 ☐ No
If Yes, Give Year or Dates: 56-59

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)
12

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Crew Chief

16b. Kind of Business/Industry

Washington Suburban Sanitary Commission

17. Father's Name (First, Middle, Last)

Emerson Knox

18. Mother's Name (First, Middle, Maiden Surname)

Grace (Unavailable)

19a. Informant's Name/Relationship (Type, Print)

Nancy J. Knox
Nancy C. Knox/Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

969 Mt. Holly Drive, Annapolis, MD 21401

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

MD Veterans Cemetery


Date

Jan. 15, 2004

20c. Location - City or Town, State

Crownsville, MD

21. Signature of Funeral Service Licensee



22. Name and Address of Facility

Barranco & Sons, P.A. Severna Park Funeral Home
495 Gov. Ritchie Hwy, Severna Park, MD 21146

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. *Cardiac arrest*
Due to (or as a consequence of):
b. *Respiratory failure*
Due to (or as a consequence of):
c. **EMPHYSEMA/COFD**
Due to (or as a consequence of):
d.

Approximate Interval Between Onset and Death

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown3 ☐ Ectopic pregnancy
5 ☐ Other (specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☒ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation
2 ☐ Accident 6 ☐ Could not be determined
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier



29c. License number

D0030741

29d. Date signed (Month, Day, Year)

1-12-04

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Jeffrey Schmidlein, M.D. 844 Ritchie Hwy, Severna Park, MD 21146

31. Date filed (Month, Day, Year)

JAN 15 2004

32. Registrar's Signature

State
Registrar

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
 Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

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 To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2004 03620

1- For
State
RegistrarPhysician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

MARY ANN LEAHY

2. Date of Death

January 22, 2004

3. Time of Death

2109 M

4a. Facility Name (If not institution, give street and number)

Atlantic General Hospital

4b. City, Town, or Location of Death

Berlin

4c. County of Death

Worcester

5. Social Security Number

499-32-7262

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

69 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
9-14-34

9. Birthplace (State or Foreign Country)

MO

Usual Residence of Decedent

10a. State

MD

10b. County

Worcester

10c. City, Town or Location

Ocean Pines

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

1212 Carrollton Lane

10f. Zip Code

21811

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: White

15. Decedent's Education
(Specify only highest grade completed)Elementary/Secondary (0-12)
12

College (1-4or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

P. Leo Luning

18. Mother's Name (First, Middle, Maiden Surname)

Margaret Dalton

19a. Informant's Name/Relationship (Type, Print)

William D. Leahy

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

Spouse 1212 Carrollton Lane, Berlin, Md, 21811

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Gardens of the Pines 1-26

Date

20c. Location - City or Town, State

Ocean Pines, Md.

21. Signature of Funeral Service Licensee

John A. Ullrich

22. Name and Address of Facility

Ullrich Funeral Home Berlin, Md.

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

a. ACUTE MYOCARDIAL INFARCTION

Due to (or as a consequence of):

Sequentially list conditions,
if any, leading to immediate
cause. First Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate
Interval Between
Onset and Death

IMMEDIATE

IF FEMALE:

23b. Was decedent pregnant

in the past 12 months?
1 ☐ Yes 2 ☐ No
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 5 ☐ Other (specify)
9 ☐ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an
autopsy
performed?
1 ☐ Yes 2 ☒ No24b. Were autopsy findings available
prior to completion of cause of
death?
1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?1 ☒ Yes 2 ☐ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☒ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending
2 ☐ Accident investigation
3 ☐ Suicide 6 ☐ Could not be
4 ☐ Homicide determined

28a. Date of Injury

(Month, Day Year)

28b. Time of
Injury

M

28c. Injury at
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
and manner stated.

29b. Signature and title of certifier

Dorothy C. Holworth, M.D.

29c. License number

D 06241

29d. Date signed (Month, Day, Year)

1-24-04

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DOROTHY C. HOLWORTH, M.D. 203 SNOW ST. SNOW HILL, MD. 21863

31. Date filed (Month, Day, Year)

JAN 26 2004

32. Registrar's Signature

Bryan B. Spauld

State
RegistrarBaltimore, Maryland 21215-0036
perm. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural," or items 23a or 28a-f show
any injury or other traumatic event, the Medical Examiner must be notified at
once.Physician
/Medical
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

E.T. 5

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2004 03621

1- For
State
RegistrarPhysician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

John Edward Latimer, Sr.

2. Date of Death

Month Day Year
01 24 04

3. Time of Death

6:09a^M

4a. Facility Name (If not institution, give street and number)

Civista Medical Center

4b. City, Town, or Location of Death

LaPlata

4c. County of Death

Charles

5. Social Security Number

213-46-8669

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

55 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
March 17, 1948

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

MD

10b. County

Charles

10c. City, Town or Location

La Plata

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

107 Morris Drive

10f. Zip Code

20646

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

1 ☐ Yes 2 ☒ No
If Yes, Give
Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.
Specify: White15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

12

16a. Decedent's Usual Occupation
(Give kind of work done during most of working

life. DO NOT use retired)

Building Inspector

16b. Kind of Business/Industry

Town

17. Father's Name (First, Middle, Last)

Evertt Burton Latimer

18. Mother's Name (First, Middle, Maiden Surname)

Billie Joline Peters

19a. Informant's Name/Relationship (Type, Print)

Emma Jean Latimer/Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

P.O. Box 92, La Plata, MD 20646

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Trinity Memorial

Date

1/29/04

20c. Location - City or Town, State

Waldorf, Maryland

21. Signature of Funeral Service Licensee

David C. Echols

M00945

22. Name and Address of Facility

AREHART-ECHOLS FUNERAL HOME, P.A.

P.O. BOX 567, LA PLATA, MD 20646

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Acute Myocardial infarction

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☐ No
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy
4 ☐ Pregnant at time of death 5 ☐ Other (specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Hypertension
diabetes mellitus

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient2 ☒ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation
2 ☐ Accident 6 ☐ Could not be determined
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

B. Kamasaki M.D.

29c. License number

D-0056949

29d. Date signed (Month, Day, Year)

1/24/04

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Baig, Kamakshi, MD 6620 Crain Hwy Suite 102 LaPlata, MD 20646

31. Date filed (Month, Day, Year)

JAN 28 2004

32. Registrar's Signature

Steven B. Spotts

State
Registrar

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

SB6

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2004 03622

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

James Henry McDowell

2. Date of Death

Jan. 30, 2004

3. Time of Death

11:10p.m.

4a. Facility Name (If not institution, give street and number)

Moran Manor

4b. City, Town, or Location of Death

Westernport

4c. County of Death

Allegheny

Funeral
Director

5. Social Security Number

232-26-1431

6. Sex

1 ☐ M ☒ F

7. Age (In yrs. last birthday)

86

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Dec. 17, 1917

9. Birthplace (State or Foreign Country)

WV

Usual Residence of Decedent

10a. State

WV

10b. County

Mineral

10c. City, Town or Location

Keyser

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

329 St. Cloud Street

10f. Zip Code

26726

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify:

white

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12th

College (1-4or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

salesman

16b. Kind of Business/Industry

Wholesale

17. Father's Name (First, Middle, Last)

Luke Parker McDowell

18. Mother's Name (First, Middle, Maiden Sumame)

Mary Elizabeth Davis

19a. Informant's Name/Relationship (Type, Print)

Richard K. Butler/POA

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

Rt. 6, Box 6014, Keyser, WV 26726

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Potomac Memorial

Date

2/02/04

20c. Location - City or Town, State

Keyser, WV

21. Signature of Funeral Service Licensee

Harold Dean Ropert

22. Name and Address of Facility

Markwood Funeral Home

P.O. Box 912, Keyser, WV 26726

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Acute Myocardial Infarction

Due to (or as a consequence of):

b. Coronary Artery Disease

Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

24 hours

years

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Diabetes mellitus

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Jesus H. Tan

29c. License number

D21244

29d. Date signed (Month, Day, Year)

Jan 31, 2004

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Dr. Jesus H. Tan., M.D. Frostburg Plaza, Frostburg, Maryland 21532

31. Date filed (Month, Day, Year)

FEB - 9 2004

32. Registrar's Signature

Jesus H. Tan

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
ExaminerTo the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2004 03623

1- For
State
RegistrarPhysician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Dixie Irma Moran

2. Date of Death
Month Day Year

January 13 2004

3. Time of Death

7:32 p^M

4a. Facility Name (If not institution, give street and number)

3220 Twin Oak Lane

4b. City, Town, or Location of Death

Huntingtown

4c. County of Death

Calvert

5. Social Security Number

577-34-0079

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

93 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

July 29, 1910

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

MD

10b. County

Calvert

10c. City, Town or Location

Huntingtown

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

3220 Twin Oak Lane

10f. Zip Code

20639

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: white

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

homemaker

16b. Kind of Business/Industry

own home

17. Father's Name (First, Middle, Last)

William Headley Trathen

18. Mother's Name (First, Middle, Maiden Surname)

Robert Jesse Iovan

19a. Informant's Name/Relationship (Type, Print)

Betty Lou Curtis, granddaughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

3838 6th St., North Beach, MD 20714

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

So. Memorial Gardens 01-17-2004

Date

20c. Location - City or Town, State

Dunkirk, MD

21. Signature of Funeral Service Licensee

William Trathen

22. Name and Address of Facility

Rausch Funeral Home, P.A., Owings, MD 20736

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Acute Myocardial Infarction

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Atherosclerotic Cardiovascular Disease

Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☒ No
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 5 ☐ Other (specify)
9 ☐ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy performed?
1 ☐ Yes 2 ☒ No24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No25. Was case referred to medical examiner?
1 ☐ Yes 2 ☒ No26. Place of Death (Check only one)
Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation
2 ☐ Accident 6 ☐ Could not be determined
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Jonathan Lowenthal

29c. License number

033123

29d. Date signed (Month, Day, Year)

1-14-04

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Jonathan Lowenthal, MD 110 Hospital Road, Ste 310, Prince Frederick, MD 20678

31. Date filed (Month, Day, Year)

JAN 14 2004

32. Registrar's Signature

Kenna B. Smith

State
Registrar

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2004 03624

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Edith M. Moore

2. Date of Death
Month Day Year
January 20, 2004

3. Time of Death
1:15PM

4a. Facility Name (If not institution, give street and number)

Somerford Place

4b. City, Town, or Location of Death

Columbia

4c. County of Death

Howard

Funeral
Director

5. Social Security Number

194-14-4812

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

78 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

May 8, 1925

9. Birthplace (State or Foreign Country)

Pennsylvania

Usual Residence of Decedent

10a. State

Maryland

10b. County

Howard

10c. City, Town or Location

Ellicott City

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

3734 Ligon Road

10f. Zip Code

21042

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

1

16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Administrative Assistant

16b. Kind of Business/Industry

College

17. Father's Name (First, Middle, Last)

Samuel Dean Matchett

18. Mother's Name (First, Middle, Maiden Surname)

Olive Irene Wilson

19a. Informant's Name/Relationship (Type, Print)

Karol Schwarzenberg/ daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

3734 Ligon Road Ellicott City, MD 21042

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Bayview Crematory, Inc.

Date

January 22, 2004

20c. Location - City or Town, State

Baltimore, Maryland

21. Signature of Funeral Service Licensee

Beverly L. Heckrotte MO1251

22. Name and Address of Facility

Going Home Cremation Service P.O. Box 784
Beverly L. Heckrotte, P.A. Clarksville, MD 21029

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Alzheimer's Disease

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☒ Other (Specify) Assisted Living

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

James P. Richardson

29c. License number

D27394

29d. Date signed (Month, Day, Year)

January 21, 2004

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

James P. Richardson, MD 3333 N. Calvert Street Suite 325 Baltimore, MD 21218

31. Date filed (Month, Day, Year)

JAN 21 2004

32. Registrar's Signature

James P. Richardson

State
Registrar

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2004 03625

1- For
State
RegistrarPhysician
/Medical
ExaminerFuneral
Director

1. Decedent's Name (First, Middle, Last) James Matthew Malloy				2. Date of Death Month January Day 17 Year 2004		3. Time of Death 4:56 PM	
4a. Facility Name (If not institution, give street and number) Charlotte Hall Veterans Center				4b. City, Town, or Location of Death Charlotte Hall		4c. County of Death St. Mary's	
5. Social Security Number 579-14-0484		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 82 Yrs.		8. Date of Birth (Month, Day, Year) April 27 1921	
9. Birthplace (State or Foreign Country) Washington, DC							
Usual Residence of Decedent							
10a. State MD		10b. County Calvert		10c. City, Town or Location Prince Frederick		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
10e. Street and Number 1800 Hallowing Point Road				10f. Zip Code 20678		10g. Citizen of What Country? USA	
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: 1944-45		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 11 College (1-4 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Mail Carrier		16b. Kind of Business/Industry US Postal Service	
17. Father's Name (First, Middle, Last) James Thomas Malloy				18. Mother's Name (First, Middle, Maiden Surname) Clara Sands			
19a. Informant's Name/Relationship (Type, Print) Jean Brown (daughter)				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1800 Hallowing Pt. Road Prince Frederick, MD 20678			
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Lee Crematory		20c. Location - City or Town, State Jan 21 2004 Clinton, MD			
21. Signature of Funeral Service Licensee Gary J. Goff				22. Name and Address of Facility Lee Funeral Home Calvert, PA 8125 Southern Maryland Blvd Owings, MD 20736			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. PULMONARY EMBOLISM Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last							
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input checked="" type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <input type="checkbox"/> Unknown				23d. Date of delivery Month Day Year	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. DEMENTIA, PERIPHERAL VASCULAR DISEASE ABOVE THE KNEE AMPUTATION, HYPERTENSION, ATRIAL FIBRILLATION, CHRONIC RENAL FAILURE						23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown	
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28d. Describe how injury occurred			
28f. Location (Street and Number or Rural Route Number, City or Town, State)							
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.							
29b. Signature and title of certifier Fulton Lukban, M.D.				29c. License number D50963		29d. Date signed (Month, Day, Year) 01/18/04	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) FULTON LUKBAN, M.D., CHVH, CHARLOTTE HALL, MD							
31. Date filed (Month, Day, Year) JAN 22 2004				32. Registrar's Signature John H. Spoke			

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 9088.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

2+1

State
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene
 1- For Amend Item 27 per ME, G829, 03/20/04 dbb Certificate of Death 2004 03626
 Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Leona Morgan Myers				2. Date of Death Month January Day 21 , Year 2004		3. Time of Death 8:34 P M	
	4a. Facility Name (If not institution, give street and number) Southern Maryland Hospital				4b. City, Town, or Location of Death Clinton		4c. County of Death Prince George's	
Funeral Director	5. Social Security Number 262-38-6041		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 72 Yrs.		8. Date of Birth (Month, Day, Year) Jun 5, 1931	
	9. Birthplace (State or Foreign Country) Florida		10a. State MD		10b. County Prince George's		10c. City, Town or Location Upper Marlboro	
10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		10e. Street and Number 12305 Sturdee Drive		10f. Zip Code 20772		10g. Citizen of What Country? USA		
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Computer Programmer		16b. Kind of Business/Industry Federal Gov't NASA				
17. Father's Name (First, Middle, Last) Leon Morgan				18. Mother's Name (First, Middle, Maiden Surname) Rachel Hatcher				
19a. Informant's Name/Relationship (Type, Print) Mary Ann Barbour (daughter)				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5908 Old Croom Station Rd. Upper Marlboro, MD 20772				
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Lee Crematory		20c. Date Jan 24 2004		20d. Location - City or Town, State Clinton, MD		
21. Signature of Funeral Service Licensee Gary J. Goff		22. Name and Address of Facility Lee Funeral Home Calvert, PA 8125 Southern Maryland Blvd. Owings, MD 20736						
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) PULMONARY EDEMA Due to (or as a consequence of): HYPERTENSION Due to (or as a consequence of): EMPHYSEMA Due to (or as a consequence of): OSTEOPOROSIS								
23b. IF FEMALE: Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown								
23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify)								
23d. Date of delivery Month Day Year								
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. LEFT HIP FRACTURE						23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Probably <input type="checkbox"/> Unknown		
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No						24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No		
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year) January 19, 2004		28b. Time of Injury 6:00 M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
28d. Describe how injury occurred Fell at home		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) home		28f. Location (Street and Number or Rural Route Number, City or Town, State) 12305 Sturdee Drive, Upper Marlboro				
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier [Signature]						
29c. License number 048158		29d. Date signed (Month, Day, Year) JAN 22, 2004						
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SISOM OSIA, M.D. 6192 OXON HILL ROAD STE 500 OXON HILL MD 20745								
31. Date filed (Month, Day, Year) JAN 26 2004		32. Registrar's Signature [Signature]						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.


State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2004 03627

1- For
State
RegistrarPhysician
/Medical
ExaminerFuneral
Director

1. Decedent's Name (First, Middle, Last) JOHN EARL MOODY				2. Date of Death Month Day Year January 23, 2004				3. Time of Death 7:30 A M			
4a. Facility Name (If not institution, give street and number) CIVISTA Medical Center				4b. City, Town, or Location of Death La Plata				4c. County of Death Charles			
5. Social Security Number 216-34-7540		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 66 Yrs.		8. Date of Birth (Month, Day, Year) DEC 28 1937		9. Birthplace (State or Foreign Country) Maryland			
10a. State Maryland				10b. County Charles		10c. City, Town or Location Waldorf				10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
10e. Street and Number 2500 Green Pine Court				10f. Zip Code 20601				10g. Citizen of What Country? USA			
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: White			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) US Armed Forces				16b. Kind of Business/Industry National Security			
17. Father's Name (First, Middle, Last) John Moody				18. Mother's Name (First, Middle, Maiden Surname) Catherine Robertson Loveless							
19a. Informant's Name/Relationship (Type, Print) Katherine D. Moody (Wife)				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2500 Green Pine Court Waldorf, Maryland 20601							
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Maryland Veterans		Date 1-29-04		20c. Location - City or Town, State Cheltenham, MD					
21. Signature of Funeral Service Licensee 		M00173		22. Name and Address of Facility Eberwein Funeral Services 4433 White Pls. La. White Pls., MD 20695							
23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Coronary Artery disease Due to (or as a consequence of): b. Hypercholesterolemia Due to (or as a consequence of): c. Due to (or as a consequence of): d. Approximate Interval Between Onset and Death 24 hours 10 years											
23b. IF FEMALE: Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown										23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) 9 <input type="checkbox"/> Unknown	
23d. Date of delivery Month Day Year											
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.										23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown	
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No										24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)									
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred			
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)									
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.											
29b. Signature and title of certifier  Rita DuBoys MD				29c. License number D47562				29d. Date signed (Month, Day, Year) 01/23/2004			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Rita DuBoys, M.D. 1050 W. Perimeter Dr. AAFB Clinton, MD 20762											
31. Date filed (Month, Day, Year) JAN 28 2004		32. Registrar's Signature 									

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar Amend Item#28e, fperME02/9/04EW Certificate of Death

Reg. No.

2004 03628

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) JAMES RYAN MARTIN			2. Date of Death Month JAN Day 12 Year 2004		3. Time of Death 1846	
	4a. Facility Name (If not institution, give street and number) 72 MARYLAND AVE #B			4b. City, Town, or Location of Death ANNAPOLIS		4c. County of Death AA	
Funeral Director	5. Social Security Number 003-64-6008		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 25 Yrs.		8. Date of Birth (Month, Day, Year) Sept. 8, 1978
	9. Birthplace (State or Foreign Country) New Hampshire						
To Be Completed by Funeral Director	Usual Residence of Decedent						
	10a. State Maryland		10b. County Anne Arundel		10c. City, Town or Location Annapolis		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
	10e. Street and Number 72 Maryland Avenue			10f. Zip Code 21401		10g. Citizen of What Country? United States	
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: white
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <input type="checkbox"/> College (1-4or 5+) <input checked="" type="checkbox"/>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) systems engineer		16b. Kind of Business/Industry engineering		
	17. Father's Name (First, Middle, Last) James E. Martin			18. Mother's Name (First, Middle, Maiden Sumame) Betty (unknown)			
	19a. Informant's Name/Relationship (Type, Print) Michael Martin/ uncle			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2606 Turf Valley Road Ellicott City, MD 21042			
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) St. Anne's Cemetery		Date Jan. 16, 2004		20c. Location - City or Town, State Annapolis, MD
	21. Signature of Funeral Service Licensee G. Scott Romanowski		22. Name and Address of Facility John M. Taylor Funeral Home, Inc 147 Duke of Gloucester St. Annapolis, MD 21401				
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Asphyxia Due to (or as a consequence of): b. Hanging Due to (or as a consequence of): c. Due to (or as a consequence of): d. Approximate Interval Between Onset and Death minutes minutes						
23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown							
23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <input type="checkbox"/> Unknown							
23d. Date of delivery Month Day Year							
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown							
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No							
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No							
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No							
26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide							
28a. Date of Injury (Month, Day, Year) 1/12/4							
28b. Time of Injury UNK							
28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No							
28d. Describe how injury occurred HUNG SELF							
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Home							
28f. Location (Street and Number or Rural Route Number, City or Town, State) 72 Maryland Ave #8 Annapolis, Md							
29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.							
29b. Signature and title of certifier William P. Jones, MD Deputy							
29c. License number D06054							
29d. Date signed (Month, Day, Year) 1/12/4							
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) William P. Jones, MD 695 America 21035							
31. Date filed (Month, Day, Year) JAN 15 2004							
32. Registrar's Signature Ann H. Apple							

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Division of Vital Records, P.O. Box 68760,

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Physician
/Medical
Examiner

Funeral
Director

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

1. Decedent's Name (First, Middle, Last) GENE MOSCHETTO		2. Date of Death Month January Day 30 Year 2004		3. Time of Death 1132 a^M	
4a. Facility Name (If not institution, give street and number) 3804 Potee Street		4b. City, Town, or Location of Death Baltimore		4c. County of Death	
5. Social Security Number UNKNOWN	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 51 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) JUNE 29, 1952
9. Birthplace (State or Foreign Country) WASHINGTON D.C.					
10a. State MD	10b. County TALBOT	10c. City, Town or Location EASTON		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
10e. Street and Number 27776 SHARP RD.		10f. Zip Code 21601		10g. Citizen of What Country? USA	
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:	
14. Race - American Indian, Black, White, etc. Specify: WHITE					
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 0		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) MANUEL LABOR		16b. Kind of Business/Industry CONSTRUCTION	
17. Father's Name (First, Middle, Last) ALBERT MOSCHETTO		18. Mother's Name (First, Middle, Maiden Surname) NORMA MYERS			
19a. Informant's Name/Relationship (Type, Print) NORMA REDELE'/MOTHER		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 27776 SHARP RD. EASTON, MD 21601			
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) CHESAPEAKE CREMATION CTR 2-1-2004		20c. Location - City or Town, State STEVENSVILLE, MD	
21. Signature of Funeral Service Licensee JOHN R. MERCERON		22. Name and Address of Facility FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME PA 200 S. HARRISON ST EASTON, MD 21601			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Seizure Disorder		a. Due to (or as a consequence of):		Approximate Interval Between Onset and Death	
b. Due to (or as a consequence of):		c. Due to (or as a consequence of):		d. Due to (or as a consequence of):	
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Unknown		23d. Date of delivery Month Day Year	
24. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		25. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) at scene		26. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown	
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M	
28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	
28f. Location (Street and Number or Rural Route Number, City or Town, State)					
29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier Maryanne P. Koren		29c. License number OCME	
29d. Date signed (Month, Day, Year) January 31 2004					
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MARYANNE P. KOREN		111 Penn Street, Baltimore, Maryland 21201			
31. Date filed (Month, Day, Year) FEB - 3 2004		32. Registrar's Signature			

State
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2004 03630

1- For State Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) LEEWORTH NICHOLS				2. Date of Death Month JANUARY Day 25 , Year 2004				3. Time of Death 11:21p M		
	4a. Facility Name (If not institution, give street and number) MALCOLM GROVE MEDICAL CENTER				4b. City, Town, or Location of Death CAMP SPRINGS				4c. County of Death PRINCE GEORGE'S		
Funeral Director	5. Social Security Number 215-49-0124		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 21 Yrs.		8. Date of Birth (Month, Day, Year) NOVEMBER 5, 1982		9. Birthplace (State or Foreign Country) GUYANA		
	Usual Residence of Decedent										
10a. State MARYLAND		10b. County PRINCE GEORGES		10c. City, Town or Location OXON HILL				10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No			
10e. Street and Number 1124 WESTFIELD DRIVE				10f. Zip Code 20746				10g. Citizen of What Country? GUYANA			
11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:			13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: BLACK		
15. Decedent's Education (Specify only highest grade completed) 12TH GRADE				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) UNEMPLOYED				16b. Kind of Business/Industry NONE			
17. Father's Name (First, Middle, Last) GEORGE NICHOLS				18. Mother's Name (First, Middle, Maiden Surname) EMELDA JONES							
19a. Informant's Name/Relationship (Type, Print) ARIAGNER BAKER / FIANCEE				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3620 16TH STREET, N.W.#501, WASHINGTON, D.C. 20010							
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) RESURRECTION CEMETERY			Date JANUARY 31, 2004		20c. Location - City or Town, State CLINTON, MARYLAND			
21. Signature of Funeral Service Licensee LEDIA C. THORNTON JOHNSON MD0583				22. Name and Address of Facility THORNTON FUNERAL HOME, P.A. 3439 LIVINGSTON ROAD, INDIAN HEAD, MARYLAND 20640							
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Multiple gunshot wounds										Approximate Interval Between Onset and Death	
23b. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last											
23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Other (specify) <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Unknown										23d. Date of delivery Month Day Year	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.										23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown	
24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No										24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input checked="" type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide				28a. Date of Injury (Month, Day Year) 1-25-04		28b. Time of Injury Found 10:44 PM		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred Subject was shot	
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) In the lobby of a store				28f. Location (Street and Number or Rural Route Number, City or Town, State) Camp Springs, MD							
29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. Signature and title of certifier L. W. Nichols M.D.				29c. License number OCME		29d. Date signed (Month, Day, Year) JANUARY 27, 2004	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) LING LI, M.D. 111 Penn Street, Baltimore, Maryland 21201											
31. Date filed (Month, Day, Year) JAN 29 2004				32. Registrar's Signature [Signature]							

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar Amend Item #28a-fpe MeoG828 2/9/04DW Certificate of Death

Reg. No.

2004 03631

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Joseph Andrew Neill			2. Date of Death Month January Day 7 Year 2004		3. Time of Death 1615 M			
	4a. Facility Name (If not institution, give street and number) 5015 Suitland Road			4b. City, Town, or Location of Death Suitland		4c. County of Death Prince George's			
Funeral Director	5. Social Security Number 212-72-3304		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 47 Yrs.		8. Date of Birth (Month, Day, Year) October 31, 1956		
	10a. State Maryland		10b. County Prince George's		10c. City, Town or Location Suitland		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
To Be Completed by Funeral Director	10e. Street and Number 5015 Suitland Road			10f. Zip Code 20746		10g. Citizen of What Country? U.S.A.			
	11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4or 5+)			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Mechanic		16b. Kind of Business/Industry Automobile			
	17. Father's Name (First, Middle, Last) Gerald G. Neill, Sr.			18. Mother's Name (First, Middle, Maiden Surname) Betty A. Alvey					
	19a. Informant's Name/Relationship (Type, Print) (Father) Gerald G. Neill, Sr.			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2808 Ritchie Road Forestville, MD 20747					
	20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Lee Crematory		Date Jan. 10, 2004		20c. Location - City or Town, State Clinton, Maryland		
	21. Signature of Funeral Service Licensee St. S. Smith M00542			22. Name and Address of Facility Lee Funeral Home, Inc. 6633 Old Alexandria Ferry Rd Clinton, MD 20735					
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Gunshot Wound to Head Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of):							Approximate Interval Between Onset and Death	
	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <input type="checkbox"/> Unknown				23d. Date of delivery Month Day Year		
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year) 1/7/2004		28b. Time of Injury Unknown M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred Self Inflicted	
29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier Salvador S. Synter		29c. License number M0053927		29d. Date signed (Month, Day, Year) January 8, 2004			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Salvador Synter, 300 Hospital Drive, Chevy Chase, Maryland									
31. Date filed (Month, Day, Year) JAN 21 2004		32. Registrar's Signature Kevin D. Sparks							

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

State
Registrar

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2004 03632

1- For
State
RegistrarPhysician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

CARLTON C PEDDICORD

2. Date of Death

Month Day Year
Jan 19 2004

3. Time of Death

0133 M

Funeral
Director

4a. Facility Name (If not institution, give street and number)

Howard County General Hospital

4b. City, Town, or Location of Death

Columbia

4c. County of Death

Howard

5. Social Security Number

212 01 7954

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

89

Yrs.

If Under 1 Year

Months

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

(Month, Day, Year)
June 21, 1914

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

MD

10b. County

Howard

10c. City, Town or Location

Ellicott City

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

4005 St. Johns Lane

10f. Zip Code

21042

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: White

15. Decedent's Education
(Specify only highest grade completed)Elementary/Secondary (0-12)
8

College (1-4 or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Foreman

16b. Kind of Business/Industry

Howard County Government

17. Father's Name (First, Middle, Last)

Robert Brent Peddicord

18. Mother's Name (First, Middle, Maiden Surname)

Helen Elizabeth Carr

19a. Informant's Name/Relationship (Type, Print)

Kelly C. Haire/Granddaughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

11436 Old Frederick Road Marriottsville, MD 21104

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Good Shepherd Cem.

Date

1-22-2004

20c. Location - City or Town, State

Ellicott City, MD

21. Signature of Funeral Service Licensee

M01044

22. Name and Address of Facility Harry H. Witzke's Family FH Inc.

4112 Old Columbia Pike Ellicott City, MD 21043

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

a. Due to (or as a consequence of):

Pneumonia

Approximate
Interval Between
Onset and Death
DaysSequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

IF FEMALE:

23b. Was decedent pregnant
in the past 12 months?1 ☐ Yes 2 ☐ No
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown3 ☐ Ectopic pregnancy
5 ☐ Other (Specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

COLD, SEPTIC SHOCK, Respiratory
failure

23e. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown24a. Was an
autopsy
performed?
1 ☒ Yes 2 ☐ No24b. Were autopsy findings available
prior to completion of cause of
death?
1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?
1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending
investigation
2 ☐ Accident 6 ☐ Could not be
determined
3 ☐ Suicide 4 ☐ Homicide28a. Date of Injury
(Month, Day Year)28b. Time of
Injury

M

28c. Injury at
Work?
1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury: At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
and manner stated.

29b. Signature and title of certifier

Pritham SS

29c. License number

D28998

29d. Date signed (Month, Day, Year)

Jan 19 2004

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

PRITHAM SSAINI MD
9101 CHERRY LANE SUITE 211, Laurel MD 20708

31. Date filed (Month, Day, Year)

JAN 20 2004

32. Registrar's Signature

Pritham SS

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show
any injury or other traumatic event, the Medical Examiner must be notified at
once.To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2004 03633

1- For
State
RegistrarPhysician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Lucille Almerna Pilkerton

2. Date of Death

January 6, 2004

3. Time of Death

4:54 p M

4a. Facility Name (If not institution, give street and number)

Washington Adventist Hospital

4b. City, Town, or Location of Death

Takoma Park

4c. County of Death

Montgomery

Funeral
Director

5. Social Security Number

168-14-1605

6. Sex

1 M 2 F

2 F

7. Age (In yrs. last birthday)

82

Yrs.

8. Date of Birth (Month, Day, Year)

4/20/1921

9. Birthplace (State or Foreign Country)

PA

Usual Residence of Decedent

10a. State

MD

10b. County

St. Mary's

10c. City, Town or Location

California

10d. Inside City Limits

1 Yes 2 No

10e. Street and Number

44041 Flagstone Way

10f. Zip Code

20619

10g. Citizen of What Country?

USA

11. Marital Status

1 Never Married 2 Married
3 Widowed 4 Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 Yes 2 No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

2

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Human Resource Specialist

16b. Kind of Business/Industry

U.S. Government

17. Father's Name (First, Middle, Last)

Cyrus C. Housel

18. Mother's Name (First, Middle, Maiden Surname)

Berdella M. Smith

19a. Informant's Name/Relationship (Type, Print)

Nadine Hiers/Niece

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

14202 Adkins Road, Laurel, Maryland 20708

20a. Method of Disposition

1 Burial 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Metropolitan Crematory 1/8/2004 Alexandria, Virginia

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

Raymond Wood

22. Name and Address of Facility

Raymond-Wood Funeral Home, P.A.
PO Box 430, Dunkirk, MD 20754

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. SEVERE RESPIRATORY INSUFFICIENCY

Due to (or as a consequence of):

b. HEART FAILURE

Due to (or as a consequence of):

c. SEVERE AORTIC VALVE DISEASE

Due to (or as a consequence of):

d.

Approximate Interval Between Onset and Death

DAYS

DAYS

YEARS

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No
9 Unknown

23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death 3 Ectopic pregnancy
4 Pregnant at time of death 5 Other (specify)
9 Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

RIGHT VENTRICULAR ISCHEMIA

RENAL INSUFFICIENCY

23e. Did tobacco use contribute to the cause of death?

1 Yes 2 No 3 Probably 4 Unknown

24a. Was an autopsy performed?

1 Yes 2 No

24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No

25. Was case referred to medical examiner?

1 Yes 2 No

Hospital:

1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify)

27. Manner of Death

1 Natural 2 Accident 3 Suicide 4 Homicide
5 Pending investigation 6 Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 Yes 2 No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

29b. Signature and title of certifier

Samir R. Neimat, MD

29c. License number

D 18551

29d. Date signed (Month, Day, Year)

1/6/04

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

SAMIR R. NEIMAT, MD. 7610 CARROLL AV. TAKOMA PARK, MD, 20912

31. Date filed (Month, Day, Year)

JAN 08 2004

32. Registrar's Signature

Kenna H. Apple

State
Registrar

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar Amend Items #28a-f per MDG828 2/9/04 Certificate of Death

Reg. No.

2004 03634

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Michael Harry Pearlman				2. Date of Death Month Day Year January 2, 2004		3. Time of Death 13:14 M	
	4a. Facility Name (If not institution, give street and number) Bouchelle and Mechanics Valley Roads				4b. City, Town, or Location of Death North East		4c. County of Death Cecil	
Funeral Director	5. Social Security Number 090-50-3174		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 45 Yrs.		8. Date of Birth (Month, Day, Year) June 6, 1958	
	9. Birthplace (State or Foreign Country) New York		10a. State Maryland		10b. County Cecil		10c. City, Town or Location Elkton	
To Be Completed by Funeral Director	10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				10e. Street and Number 985 Nottingham Road		10f. Zip Code 21921	
	10g. Citizen of What Country? United States				11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:	
To Be Completed by Physician/Medical Examiner	13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: White		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 8	
	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Professor				16b. Kind of Business/Industry Education			
To Be Completed by Physician/Medical Examiner	17. Father's Name (First, Middle, Last) Abraham Pearlman				18. Mother's Name (First, Middle, Maiden Surname) Helen Goldstein			
	19a. Informant's Name/Relationship (Type, Print) Abraham Pearlman/Father				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) P.O. Box 444, Pomona, New York 10970			
To Be Completed by Physician/Medical Examiner	20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify):				20b. Place of Disposition (Name of cemetery, crematory or other place) Mayerdale Crematory		20c. Location - City or Town, State Newark, Delaware	
	21. Signature of Funeral Service Licensed 				22. Name and Address of Facility Crouch Funeral Home 127 South Main Street, North East, Maryland 21901			
To Be Completed by Physician/Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Gunshot Wound to Head Due to (or as a consequence of): b. Depression Due to (or as a consequence of): c. Due to (or as a consequence of): d.				Approximate Interval Between Onset and Death Immediate years			
	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown				23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Other (specify) <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Unknown			
To Be Completed by Physician/Medical Examiner	23d. Date of delivery Month Day Year				24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
	24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No				25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No			
To Be Completed by Physician/Medical Examiner	26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) Bouchelle Rd				27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined			
	28a. Date of Injury (Month, Day, Year) Found 1/2/2004				28b. Time of Injury Unknown M			
To Be Completed by Physician/Medical Examiner	28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				28d. Describe how injury occurred Self Inflicted			
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Baseball Field				28f. Location (Street and Number or Rural Route Number, City or Town, State) Bouchelle & Mechanics Vall Rd NE Md			
To Be Completed by Physician/Medical Examiner	29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				29b. Signature and title of certifier 			
	29c. License number D15314				29d. Date signed (Month, Day, Year) January 5, 2004			
To Be Completed by Physician/Medical Examiner	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) H Farhas, MD Union Hospital, Elkton, MD 21921				31. Date filed (Month, Day, Year) JAN 05 2004			
	32. Registrar's Signature 							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2004 03635

1- For
State
RegistrarPhysician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Carl Wayne Robertson, Sr.

2. Date of Death

Feb. 1, 2004

3. Time of Death

6:15 PM M

4a. Facility Name (If not institution, give street and number)

Beverly Health Care Center

4b. City, Town, or Location of Death

Frederick

4c. County of Death

Frederick

5. Social Security Number

532-32-6364

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

75 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Jan. 11, 1929

9. Birthplace (State or Foreign Country)

Oklahoma

Usual Residence of Decedent

10a. State

Maryland

10b. County

Frederick

10c. City, Town or Location

Frederick

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

30 North Place

10f. Zip Code

21701

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☒ Yes 2 ☐ No
If Yes, Give Year or Dates: WW II

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Glazier/ Glass Mechanic

16b. Kind of Business/Industry

Glass Company

17. Father's Name (First, Middle, Last)

Crandle Robertson

18. Mother's Name (First, Middle, Maiden Surname)

Irene Jolly

19a. Informant's Name/Relationship (Type, Print)

Mia Brust. Public Guardian

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1440 Taney Ave., Frederick, Maryland 21702

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Smithsburg Crematory

Date

Feb. 3, 2004

20c. Location - City or Town, State

Smithsburg, Maryland

21. Signature of Funeral Service Licensee

Rich E. Gray

M00255

22. Name and Address of Facility

Keeney and Basford PA Funeral Home
106 East Church St., Frederick, MD 21701

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Aspiration pneumonia

Approximate Interval Between Onset and Death

2 Days

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

a. Due to (or as a consequence of):

End stage Dementia-Alzheimer

Yrs.

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☐ No
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy
4 ☐ Pregnant at time of death 5 ☐ Other (specify)
9 ☐ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Anemia

Dysphagia

Gait Disorder

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Allen Reilly MD

29c. License number

D 54749

29d. Date signed (Month, Day, Year)

Feb. 2, 2004

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Allen Reilly, M.D., 801 Toll House Ave., D-1, Frederick, Maryland 21701

31. Date filed (Month, Day, Year)

FEB - 9 2004

32. Registrar's Signature

[Signature]

Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.Physician
/Medical
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2004 03636

1- For State Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) BRIDGETTE THERESA REICH				2. Date of Death Month Jan Day 25 Year 2004		3. Time of Death 22:08 P M	
	4a. Facility Name (If not institution, give street and number) PENINSULA REGIONAL Medical Center				4b. City, Town, or Location of Death SALISBURY		4c. County of Death Wicomico	
Funeral Director	5. Social Security Number 222 32 3763		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 56 Yrs.	8. Date of Birth (Month, Day, Year) Dec. 11, 1947		9. Birthplace (State or Foreign Country) Georgia	
	Usual Residence of Decedent							
10a. State Maryland		10b. County Wicomico		10c. City, Town or Location Salisbury		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
10e. Street and Number 611 W. Railroad Avenue				10f. Zip Code 21801		10g. Citizen of What Country? U.S.A.		
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 2 College (1-4 or 5+) 2				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker		16b. Kind of Business/Industry Family		
17. Father's Name (First, Middle, Last) Leroy Foreman				18. Mother's Name (First, Middle, Maiden Surname) Maureen Morris				
19a. Informant's Name/Relationship (Type, Print) Frederick Paul Reich				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) P.O. Box 4122 Salisbury, MD 21803				
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Cape Henlopen Crem.		Date 1/26/04		20c. Location - City or Town, State Frankford, DE		
21. Signature of Funeral Service Licensee <i>[Signature]</i>				22. Name and Address of Facility 108 William St. Burbage Funeral Home Berlin, MD 21811				
23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. congestive heart failure Due to (or as a consequence of): b. ischemic coronary artery disease Due to (or as a consequence of): c. Due to (or as a consequence of): d.								
Approximate Interval Between Onset and Death 2-3 years								
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Unknown <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Other (specify)		23d. Date of delivery Month Day Year				
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Chronic obstructive pulmonary disease Arteriosclerotic insufficiency						23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No						
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input checked="" type="checkbox"/> OOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
28d. Describe how injury occurred				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				
28f. Location (Street and Number or Rural Route Number, City or Town, State)								
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.								
29b. Signature and title of certifier Rodney A. Wenrich, M.D.				29c. License number D 15384		29d. Date signed (Month, Day, Year) 1/26/04		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) RODNEY A. WENRICH 1346 S. DIVISION ST. SALISBURY MD 21804								
31. Date filed (Month, Day, Year) JAN 27 2004				32. Registrar's Signature <i>[Signature]</i>				

To Be Completed by Funeral Director

Medical Certification; To Be Completed by Physician/Medical Examiner

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial/transit

Bridgette Reich
222-32-3763
Baltimore, Maryland 21215-0036

Baltimore, Maryland 21215-0036
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show
any injury or other traumatic event, the Medical Examiner must be notified at
once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Physician
/Medical
Examiner

Funeral
Director

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last) Helen C. Rapheal		2. Date of Death Month Day Year January 5, 2004		3. Time of Death 6:45 P M	
4a. Facility Name (If not institution, give street and number) Calvert Memorial Hospital		4b. City, Town, or Location of Death Prince Frederick		4c. County of Death Calvert	
5. Social Security Number 488-36-1615 438-36-1615		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (in yrs. last birthday) 79 Yrs.	
8. Date of Birth (Month, Day, Year) May 1, 1924		9. Birthplace (State or Foreign Country) Texas			
10a. State MD		10b. County Prince Georges		10c. City, Town or Location Fort Washington	
10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		10e. Street and Number 6215 Dimrill Court		10f. Zip Code 20744	
10g. Citizen of What Country? USA		11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:	
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White Black			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 2		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Registered Nurse		16b. Kind of Business/Industry Hospital	
17. Father's Name (First, Middle, Last) Smallest		18. Mother's Name (First, Middle, Maiden Surname) Louise Lassaint			
19a. Informant's Name/Relationship (Type, Print) Michael J. Roy		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) P. O. Box 149 Borger, TX 79008-0149			
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Resurrection Cemetery 2004		20c. Location - City or Town, State Clinton, Maryland	
21. Signature of Funeral Service Licensee Gary J. Goff		22. Name and Address of Facility Lee Funeral Home Calvert, PA 8125 Southern Maryland Blvd. Owings, MD 20736			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Pneumonia Due to (or as a consequence of): Anemia, idiopathic hemolytic Conjunctive heart failure Hypercapnic respiratory failure		Approximate Interval Between Onset and Death days months weeks days			
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 9 <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) 9 <input type="checkbox"/> Unknown		23d. Date of delivery Month Day Year	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. lymphoma Urinary tract infection Hypertension		23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown		24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)	
27. Manner of Death 1 <input type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year) 28b. Time of Injury M 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		28d. Describe how injury occurred	
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier Adeeb Taker, MD, Hospitalist		29c. License number D 60390	
29d. Date signed (Month, Day, Year) 1/6/04		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Adeeb Taker, MD, 100 Hospital Rd., Prince Frederick, MD 20676			
31. Date filed (Month, Day, Year) JAN 08 2004		32. Registrar's Signature Beverly H. Spivey			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2004 03638

1- For State Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Thelma Elizabeth Ruth				2. Date of Death Month Day Year January 27 2004		3. Time of Death 745 A M		
	4a. Facility Name (If not institution, give street and number) Calvert Memorial Hospital			4b. City, Town, or Location of Death Prince Frederick		4c. County of Death Calvert			
Funeral Director	5. Social Security Number 220 16 0394		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 80 Yrs.	8. Date of Birth (Month, Day, Year) June 26 1923		9. Birthplace (State or Foreign Country) West Virginia		
	Usual Residence of Decedent								
To Be Completed by Funeral Director	10a. State Maryland		10b. County Calvert		10c. City, Town or Location Lusby		10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
	10e. Street and Number 846 Forest Glen Road			10f. Zip Code 20657		10g. Citizen of What Country? United States			
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: white		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4or 5+) 12		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) homemaker		16b. Kind of Business/Industry own home				
	17. Father's Name (First, Middle, Last) Ernest Cline				18. Mother's Name (First, Middle, Maiden Surname) Laura Hardy				
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) Cheryl A. Daniel - daughter				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 256 King Arthur Dr. Woodstock, Georgia 30189				
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Solomons Methodist Cemetery		Date Jan 30 2004		20c. Location - City or Town, State Solomons Maryland		
	21. Signature of Funeral Service Licensee B. Rausch				22. Name and Address of Facility Rausch Funeral Home PA 4405 Broomes Is. rd. Port Republic MD 20676				
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Respiratory failure Due to (or as a consequence of): b. chronic lung disease Due to (or as a consequence of): c. congestive heart failure Due to (or as a consequence of): d.							Approximate Interval Between Onset and Death	
	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify)		23d. Date of delivery Month Day Year				
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23e. Did tobacco use contribute to the cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown			
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No							
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)							
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		28d. Describe how injury occurred	
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)							
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier K. Yazzani		29c. License number D17168		29d. Date signed (Month, Day, Year) 1/27/04			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) K. Yazzani Huntingtown MD 20639									
31. Date filed (Month, Day, Year) JAN 28 2004		32. Registrar's Signature [Signature]							

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

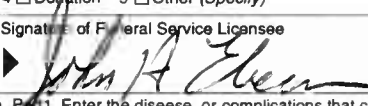
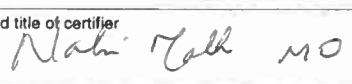

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2004 03639

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) MARGARET S. SCOTT				2. Date of Death Month January Day 23 Year 2004				3. Time of Death 12:55 PM		
	4a. Facility Name (If not institution, give street and number) Charles County Nursing & Rehab Center				4b. City, Town, or Location of Death La Plata				4c. County of Death Charles		
Funeral Director	5. Social Security Number 206-18-1208		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 78 Yrs.		8. Date of Birth (Month, Day, Year) JAN 9 1926		9. Birthplace (State or Foreign Country) Pennsylvania		
	Usual Residence of Decedent										
10a. State Maryland		10b. County Charles		10c. City, Town or Location Waldorf				10d. Inside City Limits <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No			
10e. Street and Number 2448 Indian Court				10f. Zip Code 20601				10g. Citizen of What Country? USA			
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: White			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 4 College (1-4 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Registered Nurse				16b. Kind of Business/Industry Education			
17. Father's Name (First, Middle, Last) John H. Shifler				18. Mother's Name (First, Middle, Maiden Surname) Elizabeth Retberg Shifler							
19a. Informant's Name/Relationship (Type, Print) Greg W. Scott (son)				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2448 Indian Court Waldorf, MD 20601							
20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Metropolitan Crematory		Date 1-25-04		20c. Location - City or Town, State Alexandria, VA					
21. Signature of Funeral Service Licensee 		M00173		22. Name and Address of Facility Eberwein Funeral Services 4433 White Pls. La. White Plains, MD 20695							
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Breast Cancer a. Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last										Approximate Interval Between Onset and Death	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.										23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown	
										24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
										24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)									
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred			
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)					
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.											
29b. Signature and title of certifier 				29c. License number D 52289		29d. Date signed (Month, Day, Year) 1/24/2004					
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) Nalin Mathur, M.D. 10 St Patricks Drive Waldorf, MD Suite 404											
31. Date filed (Month, Day, Year) JAN 27 2004		32. Registrar's Signature 									

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2004 03640

1- For
State
RegistrarPhysician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Raphael

Smith

2. Date of Death
Month Day Year
January 5 20043. Time of Death
12:22 p^MFuneral
Director

4a. Facility Name (If not institution, give street and number)

Calvert Memorial Hospital

4b. City, Town, or Location of Death

Prince Frederick

4c. County of Death

Calvert

5. Social Security Number

none

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth (Month, Day, Year)

Jan. 5, 2004

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

MD

10b. County

Calvert

10c. City, Town or Location

Chesapeake Beach

10d. Inside City Limits

☐ Yes ☒ No

10e. Street and Number

6415 3rd Street

10f. Zip Code

20732

10g. Citizen of What Country?

USA

11. Marital Status

☒ Never Married ☐ Married
☐ Widowed ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

☐ Yes ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

☐ Yes ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

0

College (1-4or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

none

16b. Kind of Business/Industry

17. Father's Name (First, Middle, Last)

Raphael

Smith

18. Mother's Name (First, Middle, Maiden Surname)

Roseline

Moshi

19a. Informant's Name/Relationship (Type, Print)

Roseline Smith, mother

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

Box 206, Chesapeake Beach, MD 20732

20a. Method of Disposition

☐ Burial ☒ Cremation ☐ Removal from State
☐ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Metropolitan Crematory 01/13-2004 Alexandria, VA

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

William R. Smith

22. Name and Address of Facility

Rausch Funeral Home, P.A., Owings, MD 20736

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Re-Viable

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Respiratory arrest

Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

☐ Yes ☒ No ☐ Unknown

23c. If yes, outcome of pregnancy

☐ Live birth ☐ Fetal death ☐ Ectopic pregnancy
☐ Pregnant at time of death ☐ Other (specify)
☐ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

☐ Yes ☒ No ☐ Probably ☐ Unknown

24a. Was an autopsy performed?

☐ Yes ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

☐ Yes ☐ No

25. Was case referred to medical examiner?

☐ Yes ☒ No

Hospital:

☒ Inpatient☐ ER/Outpatient☐ DOA

Other:

☐ Nursing Home ☐ Residence ☐ Other (Specify)

27. Manner of Death

☒ Natural ☐ Pending investigation
☐ Accident ☐ Could not be determined
☐ Suicide ☐ Homicide

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

☐ Yes ☒ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Michelle Johnson

29c. License number

D0051814

29d. Date signed (Month, Day, Year)

Jan. 5, 2004

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Michelle Johnson, M.D., 110 Hospital Rd., Ste 211, Prince Frederick, MD 20678

31. Date filed (Month, Day, Year)

JAN 14 2004

32. Registrar's Signature

Beverly B. Sparks

State
Registrar

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Anthony J. Smith Sr.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2004 03641

Physician
/Medical
ExaminerFuneral
Director

1. Decedent's Name (First, Middle, Last) Anthony Joel Smith, Sr.		2. Date of Death Month Day Year January 18 2004		3. Time of Death 649 a M	
4a. Facility Name (If not institution, give street and number) Calvert Memorial Hospital		4b. City, Town, or Location of Death Prince Frederick		4c. County of Death Calvert	
5. Social Security Number 214-40-0807		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 64 Yrs.	
8. Date of Birth (Month, Day, Year) Aug 26, 1939		9. Birthplace (State or Foreign Country) Wash., D.C.			
Usual Residence of Decedent					
10a. State MD		10b. County Calvert		10c. City, Town or Location Prince Frederick	
10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
10e. Street and Number 110 Dresser Avenue		10f. Zip Code 20678		10g. Citizen of What Country? USA	
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:	
14. Race - American Indian, Black, White, etc. Specify: white					
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 11 College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) bricklayer, contractor		16b. Kind of Business/Industry construction	
17. Father's Name (First, Middle, Last) David Fillmore Smith		18. Mother's Name (First, Middle, Maiden Surname) Eleanor Marie Kolipinski			
19a. Informant's Name/Relationship (Type, Print) Angela E. Smith, wife		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 110 Dresser Avenue, Prince Frederick, MD 20678			
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Metropolitan Crematory 01-20-04		20c. Location - City or Town, State Alexandria, VA	
21. Signature of Funeral Service Licensee 		22. Name and Address of Facility Rausch Funeral Home, P.A., Owings, MD 20736			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Atherosclerotic Cardiovascular disease Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last					
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <input checked="" type="checkbox"/> Unknown		23d. Date of delivery Month Day Year	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Chronic alcoholism					
23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown					
24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No			
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No					
26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input checked="" type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M	
28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred			
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.					
29b. Signature and title of certifier 		29c. License number OCME		29d. Date signed (Month, Day, Year) January 19 2004	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) LIN G LI, M.D. 111 Penn Street, Baltimore, Maryland 21201					
31. Date filed (Month, Day, Year) JAN 20 2004		32. Registrar's Signature 			

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
ExaminerTo the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



8

State
Registrar

JOSEPH R. SILVER
04-00184
DAP

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Unpend
State of Maryland / Department of Health and Mental Hygiene
1- For Amend Items 1, 23a, 27, 28a-1 epr ME, C828, 02/13/04 dnb
Certificate of Death
Reg. No. 2004 03642

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Joseph Raymond Silver			2. Date of Death Month JANUARY Day 7 Year 2004			3. Time of Death 7:18 p M		
	4a. Facility Name (If not institution, give street and number) 1103 SAN ANGELO DRIVE			4b. City, Town, or Location of Death LUSBY			4c. County of Death CALVERT		
Funeral Director	5. Social Security Number 266 10 9936		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 82 Yrs.	8. Date of Birth (Month, Day, Year) Aug 16 1921		9. Birthplace (State or Foreign Country) West Virginia		
	10a. State Maryland			10b. County Calvert		10c. City, Town or Location Lusby			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
10e. Street and Number 1103 San Angelo Drive			10f. Zip Code 20657			10g. Citizen of What Country? United States			
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify White		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+)			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) merchant marine			16b. Kind of Business/Industry Seaman			
17. Father's Name (First, Middle, Last) James Raymond Silver			18. Mother's Name (First, Middle, Maiden Surname) Margaret Ruth Allen						
19a. Informant's Name/Relationship (Type, Print) Jackie L. Teller - sister			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 532 Acagona Blvd. Virginia Beach VA 23462						
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) Metropolitan Funeral Service			20c. Location - City or Town, State Alexandria Virginia			
21. Signature of Funeral Service Licensee 			22. Name and Address of Facility Rausch Funeral Home PA 4405 Brookes Is. RD. Port Republic MD 20676						
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Head Injuries complicating chronic alcohol abuse						Approximate Interval Between Onset and Death		
	23b. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last a. Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of):								
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown			23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <input checked="" type="checkbox"/> Unknown			23d. Date of delivery Month Day Year			
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown			
24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No						24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No			
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No			26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) AT SCENE						
27. Manner of Death <input type="checkbox"/> Natural <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined			28a. Date of Injury (Month, Day Year) 01/05/2004		28b. Time of Injury 6:30p		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Residence			28d. Describe how injury occurred Decedent fell down stairs						
28f. Location (Street and Number or Rural Route Number, City or Town, State) 1103 San Angelo Drive, Lusby, MD									
29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated			29b. Signature and title of certifier 			29c. License number OCME		29d. Date signed (Month, Day, Year) JANUARY 8, 2003	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ZABINWAH ALI			111 Penn Street, Baltimore, Maryland 21201						
31. Date filed (Month, Day, Year) JAN 12 2004			32. Registrar's Signature 						

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2004 03643

1- For
State
RegistrarPhysician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Thomas Saul

2. Date of Death

Jan. 23 2004

3. Time of Death

3:42 PM

4a. Facility Name (If not institution, give street and number)

University of Maryland Med. CTR

4b. City, Town, or Location of Death

Baltimore City

4c. County of Death

Baltimore City

Funeral
Director

5. Social Security Number

577 54 4769

6. Sex

XX M 2 F

7. Age (In yrs. last birthday)

63 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Nov 11, 1940

9. Birthplace (State or Foreign Country)

Washington DC

Usual Residence of Decedent

10a. State

Maryland

10b. County

Howard

10c. City, Town or Location

Jessup

10d. Inside City Limits

1 Yes 2 No XX

10e. Street and Number

P.O. Box 534

10f. Zip Code

20794

10g. Citizen of What Country?

United States

11. Marital Status

1 Never Married 2 Married

3 Widowed XXX Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No

If Yes, Give Year or Dates: XX

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 Yes 2 No XX

Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Mail Carrier

16b. Kind of Business/Industry

U.S. Postal Service

17. Father's Name (First, Middle, Last)

Carl E. Saul

18. Mother's Name (First, Middle, Maiden Surname)

Helen Reynolds

19a. Informant's Name/Relationship (Type, Print)

Jean H. Crile (Sister)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

26528 Meadow Wood Drive, Mechanicsville, MD 20659

20a. Method of Disposition

1 Burial 2 XX Cremation 3 Removal from State

4 Donation 5 Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Lee Crematory Jan 26, 2004

Date

20c. Location - City or Town, State

Clinton, Maryland

21. Signature of Funeral Service Licensee

[Signature] 100153

22. Name and Address of Facility

Lee Funeral Home, Inc 66330ld Alexandria Ferry Road, Clinton, Maryland 20735

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. myocardial infarction

Due to (or as a consequence of):

b. coronary artery disease

Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

3 days

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No

9 Unknown

23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death

4 Pregnant at time of death

9 Unknown

3 Ectopic pregnancy

5 Other (specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

hypertension

23e. Did tobacco use contribute to the cause of death?

1 Yes 2 No 3 X Probably 4 Unknown

24a. Was an autopsy performed?

1 Yes 2 No

24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No

25. Was case referred to medical examiner?

1 Yes 2 No

Hospital:

Inpatient

2 ER/Outpatient 3 DOA

26. Place of Death (Check only one)

4 Nursing Home 5 Residence 6 Other (Specify)

27. Manner of Death

1 Natural

2 Accident

3 Suicide

4 Homicide

5 Pending investigation

6 Could not be determined

7

8

9

10

11

12

13

14

15

16

17

18

19

20

21

22

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 Yes 2 No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

X Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

[Signature] Henry, Jr.

29c. License number

D0053308

29d. Date signed (Month, Day, Year)

1/23/04

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

University of Maryland Medical Center

22 South Greene St. Baltimore MD 21228

31. Date filed (Month, Day, Year)

JAN 29 2004

32. Registrar's Signature

[Signature]

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2004 03644




1- For State Registrar

Physician /Medical Examiner

Funeral Director

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

1. Decedent's Name (First, Middle, Last) Thomas J. Twomey		2. Date of Death Month Day Year January 13 2004		3. Time of Death 3:00p^M	
4a. Facility Name (If not institution, give street and number) Anne Arundel Medical Center		4b. City, Town, or Location of Death Annapolis		4c. County of Death Anne Arundel	
5. Social Security Number 579-40-2362		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (in yrs. last birthday) 78 Yrs.	
8. Date of Birth (Month, Day, Year) July 6, 1925		9. Birthplace (State or Foreign Country) Washington, D.C.			
10a. State MD		10b. County Anne Arundel		10c. City, Town or Location Shady Side	
10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		10e. Street and Number 4923 Thomas Drive		10f. Zip Code 20764	
10g. Citizen of What Country? USA		11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates:	
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: white			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 4 College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) electrical engineer		16b. Kind of Business/Industry General Electric Co.	
17. Father's Name (First, Middle, Last) Richard Nagle		18. Mother's Name (First, Middle, Maiden Surname) Frances Cleveland Brennan			
19a. Informant's Name/Relationship (Type, Print) Mary E. Cotnoir, sister		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 17 Stephen Lane, Westfield, MA 01085			
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Metropolitan Crematory 01-15-04		20c. Location - City or Town, State Alexandria, VA	
21. Signature of Funeral Service Licensee 		22. Name and Address of Facility Rausch Funeral Home, P.A., Owings, MD 20736			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Cerebrovascular Accident Due to (or as a consequence of): b. Paroxysmal Atrial Fibrillation Due to (or as a consequence of): c. Ischemic cardiomyopathy Due to (or as a consequence of): d. Coronary Atherosclerotic heart disease		Approximate Interval Between Onset and Death 8 hrs. 3 years 12 years 12 years			
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify)		23d. Date of delivery Month Day Year	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. myelodysplasia with Pancytopenia END STAGE kidney disease on hemodialysis		23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death Check only one Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> OOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)	
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M	
28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	
28f. Location (Street and Number or Rural Route Number, City or Town, State)		29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier 	
29c. License number DD8314		29d. Date signed (Month, Day, Year) 01/13/2004			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) George C. Samaras MD 176 Defense Highway Annapolis, MD 21401		31. Date filed (Month, Day, Year) JAN 16 2004		32. Registrar's Signature 	

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 38760,

15+1

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2004 03645

1- For
State
Registrar

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) James Alton Travis, Sr.			2. Date of Death Month January Day 18 Year 2004		3. Time of Death 6:15 a M	
	4a. Facility Name (If not institution, give street and number) Calvert Memorial Hospital			4b. City, Town, or Location of Death Prince Frederick		4c. County of Death Calvert	
Funeral Director	5. Social Security Number 214-16-5645	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 81 Yrs.	8. Date of Birth (Month, Day, Year) Dec 15, 1922		9. Birthplace (State or Foreign Country) Virginia	
	Usual Residence of Decedent			10a. State MD			
To Be Completed by Funeral Director	10b. County Calvert		10c. City, Town or Location Prince Frederick		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
	10e. Street and Number 5890 Ketch Road		10f. Zip Code 20678		10g. Citizen of What Country? USA		
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: white
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) electrician, electrical contractor		16b. Kind of Business/Industry construction		
	17. Father's Name (First, Middle, Last) Aaron James Travis		18. Mother's Name (First, Middle, Maiden Surname) Nina Thomas				
	19a. Informant's Name/Relationship (Type, Print) Tracey T. Long, daughter		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 26810 County Rd. 98, Davis, CA 95616				
	20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Metropolitan Crematory		20c. Location - City or Town, State 01-20-04 Alexandria, VA		
	21. Signature of Funeral Service Licensee 		22. Name and Address of Facility Rausch Funeral Home, P.A., Owings, MD 20736				
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Metastatic Cancer of Head & Neck Due to (or as a consequence of): b. _____ Due to (or as a consequence of): c. _____ Due to (or as a consequence of): d. _____ Approximate Interval Between Onset and Death More than 1 year						
	23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown						
23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Other (specify) <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Unknown							
23d. Date of delivery Month _____ Day _____ Year _____							
Medical Certification; To Be Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Prostate Cancer Gastroesophageal Reflux disease						23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown
	24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No						24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No						
	26. Place of Death Check only one Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
	28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)		
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.						
	29b. Signature and title of certifier 		29c. License number D50653		29d. Date signed (Month, Day, Year) 1-18-2004		
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 5851 Deale Churchton Road Deale MD 20751						
	31. Date filed (Month, Day, Year) JAN 20 2004		32. Registrar's Signature 				

10+1

State
Registrar

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2004 03646

1- For
State
RegistrarPhysician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Beulah Opal Tallman

2. Date of Death

January 17, 2004

3. Time of Death

6:25 A M

Funeral
Director

4a. Facility Name (If not institution, give street and number)

Calvert Memorial Hospital

4b. City, Town, or Location of Death

Prince Frederick

4c. County of Death

Calvert

5. Social Security Number

523-28-3309

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

90 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Oct. 13, 1913

9. Birthplace (State or Foreign Country)

Kansas

Usual Residence of Decedent

10a. State

MD

10b. County

Calvert

10c. City, Town or Location

Solomons

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

13325 Dowell Road

10f. Zip Code

20688

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4or 5+)

-

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

Charles Bittner

18. Mother's Name (First, Middle, Maiden Surname)

Mary Scharman

19a. Informant's Name/Relationship (Type, Print)

Dorothy J. Underwood (DAUGHTER)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

15511 Lakeshore Villa Dr. Lot 87 Tampa, FL 33613

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Metropolitan Crematory Jan. 19, 2004 Alexandria, VA

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

[Signature]

MO 1095

22. Name and Address of Facility

Rausch Funeral Home, P.A.
4405 Broomes Island Rd. Port Republic, MD 20676

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. CARDIOPULMONARY ARREST

Due to (or as a consequence of):

b. CEREBROVASCULAR DISEASE

Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Approximate Interval Between Onset and Death

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☒ No
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy
4 ☐ Pregnant at time of death 5 ☐ Other (specify)
9 ☐ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

ALZHEIMER'S DEMENTIA

ANEMIA

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☒ Yes 2 ☐ No

Hospital:

1 ☐ Inpatient2 ☒ Outpatient3 ☐ DOA

Other:

26. Place of Death (Check only one)

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

[Signature]

29c. License number

D58385

29d. Date signed (Month, Day, Year)

Jan. 18, 2004

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Olivia Johnson, M.D. 110 Hospital Rd. # 310 Prince Frederick, MD 20678

31. Date filed (Month, Day, Year)

JAN 20 2004

32. Registrar's Signature

[Signature]

State
Registrar

Baltimore, Maryland 21215-0036

perml. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "nature", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

1- For
State
Registrar

2004 03647

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

MARY BESSIE THOMAS

2. Date of Death

January 26, 2004

3. Time of Death

1:30 A M

4a. Facility Name (If not institution, give street and number)

12560 SHILOH CHURCH ROAD

4b. City, Town, or Location of Death

NEWBURG

4c. County of Death

CHARLES

Funeral
Director

5. Social Security Number

579-42-3767

6. Sex

☐ M ☒ F

7. Age (In yrs. last birthday)

75 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

JAN 19, 1929

9. Birthplace (State or Foreign Country)

MARYLAND

Usual Residence of Decedent

10a. State

MD

10b. County

CHARLES

10c. City, Town or Location

NEWBURG

10d. Inside City Limits

☐ Yes ☒ No

10e. Street and Number

12560 SHILOH CHURCH ROAD

10f. Zip Code

20664

10g. Citizen of What Country?

UNITED STATES

11. Marital Status

☐ Never Married ☐ Married☒ Widowed ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

☐ Yes ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

☐ Yes ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: BLACK

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

11

College (1-4 or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired)

HOMEMAKER

16b. Kind of Business/Industry

PRIVATE

17. Father's Name (First, Middle, Last)

FRANCIS GREEN

18. Mother's Name (First, Middle, Maiden Surname)

REBECCA ANN GREEN

19a. Informant's Name/Relationship (Type, Print)

MARY P. CHERRY/DAUGHTER

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

3730 MIDLOTHIAN PLACE, WALDORF, MD 20602

20a. Method of Disposition

☒ Burial ☐ Cremation ☐ Removal from State☐ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

SHILOH UNITED METH CH. CEM 01/30/2004

Date

20c. Location - City or Town, State

NEWBURG, MARYLAND

21. Signature of Funeral Service Licensee

LYDIA C. THORNTON JOHNSON M00583

22. Signature of Funeral Home, P.A.

3439 LIVINGSTON ROAD, INDIAN HEAD, MD 20640

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. BRONCHOGENIC CARCINOMA

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

☐ Yes ☒ No☐ Unknown

23c. If yes, outcome of pregnancy

☐ Live birth ☐ Fetal death☐ Pregnant at time of death☐ Unknown☐ Ectopic pregnancy☐ Other (specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

☒ Yes ☐ No ☐ Probably ☐ Unknown

24a. Was an autopsy performed?

☐ Yes ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

☐ Yes ☒ No

25. Was case referred to medical examiner?

☐ Yes ☒ No

26. Place of Death (Check only one)

Hospital: ☐ Inpatient ☐ ER/Outpatient ☐ DOAOther: ☐ Nursing Home ☒ Residence ☐ Other (Specify)

27. Manner of Death

☒ Natural☐ Accident☐ Suicide☐ Homicide☐ Pending investigation☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

☐ Yes ☒ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

MD

29c. License number

DS3885

29d. Date signed (Month, Day, Year)

1/26/2004

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

VENKAT. S. RAMANATHAN 50 Post Office Road #101 Waldorf MD 20602

31. Date filed (Month, Day, Year)

JAN 29 2004

32. Registrar's Signature

[Signature]

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2004 03648

1- For
State
RegistrarPhysician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Lester Benton Varney, Sr.

2. Date of Death

January 16 2004

3. Time of Death

2:28 p M

4a. Facility Name (If not institution, give street and number)

Calvert Memorial Hospital

4b. City, Town, or Location of Death

Prince Frederick

4c. County of Death

Calvert

5. Social Security Number

235-62-6967

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

63 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
Dec 20, 1940

9. Birthplace (State or Foreign Country)

West Virginia

Usual Residence of Decedent

10a. State

MD

10b. County

Calvert

10c. City, Town or Location

Huntingtown

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

5571 Stephen Reid Road

10f. Zip Code

20639

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: white

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

feeder truck driver

16b. Kind of Business/Industry

United Parcel Service

17. Father's Name (First, Middle, Last)

Floyd

Varney

18. Mother's Name (First, Middle, Maiden Surname)

Merrill

Skeens

19a. Informant's Name/Relationship (Type, Print)

Judi Carol Varney, wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

5571 Stephen Reid Road, Huntingtown, MD 20639

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☒ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Highland Mem. Gardens 01-22-04

Date

20c. Location - City or Town, State

Godby Heights, WV

21. Signature of Funeral Service Licensee

William B. Am...

22. Name and Address of Facility

Rausch Funeral Home, P.A., Owings, MD 20736

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

Acute Pulmonary Embolism

Due to (or as a consequence of):

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate
Interval Between
Onset and Death

IF FEMALE:

23b. Was decedent pregnant

in the past 12 months?
1 ☐ Yes 2 ☐ No
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy
4 ☐ Pregnant at time of death 5 ☐ Other (specify)
9 ☐ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Non Hodgkins Lymphoma

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an
autopsy
performed?
1 ☐ Yes 2 ☒ No24b. Were autopsy findings available
prior to completion of cause of
death?
1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?1 ☒ Yes 2 ☐ No

Hospital:

1 ☐ Inpatient 2 ☒ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending
investigation
2 ☐ Accident 6 ☐ Could not be
determined
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury

(Month, Day Year)

28b. Time of

Injury

28c. Injury at

Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Jonathan Lowenthal

29c. License number

D 33123

29d. Date signed (Month, Day, Year)

Jan. 16, 2004

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Jonathan Lowenthal, M.D., 110 Hospital Rd., Ste 310, Pr. Fred., MD 20678

31. Date filed (Month, Day, Year)

JAN 20 2004

32. Registrar's Signature

Brian B. Spiller

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

10

State
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2004 03649

1- For
State
RegistrarPhysician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

DOROTHY SARAH WELLS

2. Date of Death
Month Day Year

1 23 04 4:30 P M

3. Time of Death

4a. Facility Name (If not institution, give street and number)

Atlantic General Hospital

4b. City, Town, or Location of Death

Berlin

4c. County of Death

Worcester

Funeral
Director

5. Social Security Number

154-05-1291

6. Sex

1 ☐ M ☒ F

7. Age (In yrs. last birthday)

85 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth (Month, Day, Year)

9/14/1918

9. Birthplace (State or Foreign Country)

NJ

Usual Residence of Decedent

10a. State

MD

10b. County

Worcester

10c. City, Town or Location

Berlin

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

109 Graham Ave.

10f. Zip Code

21811

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)
12

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

Raymond Wilson

18. Mother's Name (First, Middle, Maiden Surname)

Mattie Borden

19a. Informant's Name/Relationship (Type, Print)

Frances Wells

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

109 Graham Ave. Berlin, MD 21811

20a. Method of Disposition

1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☒ Other (Specify) Entombment

20b. Place of Disposition (Name of cemetery, crematory or other place)

Granite Memorials

Date

1/26/04

20c. Location - City or Town, State

Bishopville, MD

21. Signature of Funeral Service Licensee

The Burbage Funeral Home

22. Name and Address of Facility

108 William St. Berlin, MD 21811

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. cerebrovascular accident

Approximate Interval Between Onset and Death

5 days

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. stroke P. bulbar

2 years

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☒ No
9 ☐ Unknown23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown3 ☐ Ectopic pregnancy
5 ☐ Other (specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy performed?
1 ☐ Yes 2 ☒ No24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No25. Was case referred to medical examiner?
1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural 5 ☐ Pending investigation
2 ☐ Accident 6 ☐ Could not be determined
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Physician D.O.

29c. License number

H44283

29d. Date signed (Month, Day, Year)

1/24/04

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Robert Durkin 9733 Hazelbury Drive Berlin, MD 21811

31. Date filed (Month, Day, Year)

JAN 27 2004

32. Registrar's Signature

Karen H. Sparks

State
Registrar

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Dorothy Wells DOB 9/14/1918
154-05-1291 DOB 1/23/2004 1630
Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death


Reg. No.

2004 03650

1- For
State
RegistrarPhysician
/Medical
ExaminerFuneral
Director

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

1. Decedent's Name (First, Middle, Last) Myrtle Louise Worley		2. Date of Death Month January Day 9 , Year 2004		3. Time of Death 5:00 p M	
4a. Facility Name (If not institution, give street and number) Millennium Health & Rehab. Center		4b. City, Town, or Location of Death Edgewater		4c. County of Death Anne Arundel	
5. Social Security Number 230-10-1732	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 88 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) Oct. 16, 1915
9. Birthplace (State or Foreign Country) Virginia					
Usual Residence of Decedent					
10a. State Maryland	10b. County Anne Arundel	10c. City, Town or Location Edgewater		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
10e. Street and Number 144 Washington Road		10f. Zip Code 21037		10g. Citizen of What Country? U.S.A.	
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:	
14. Race - American Indian, Black, White, etc. Specify: white					
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 8 College (1-4 or 5+) College		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Manager		16b. Kind of Business/Industry Retail Shoe Store	
17. Father's Name (First, Middle, Last) John Hash			18. Mother's Name (First, Middle, Maiden Surname) Nannie Cochran		
19a. Informant's Name/Relationship (Type, Print) Lenora E. Hankins, Daughter in law			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 251 Sun Park Lane, Huntingtown, MD 20639		
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Metropolitan Crematory Jan. 14, 2004 Alexandria, VA		20c. Location - City or Town, State	
21. Signature of Funeral Service Licensee 		22. Name and Address of Facility Rausch Funeral Home, P.A., Owings, MD 20736			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Cardiac Arrhythmia Due to (or as a consequence of): b. Atherosclerotic Cardiovascular disease Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		Approximate Interval Between Onset and Death 10 minutes more than 5 yrs.			
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <input type="checkbox"/> Unknown		23d. Date of delivery Month Day Year	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Advance End Stage dementia Hypothyroidism Left Bundle Branch Block				23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown	
24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M	
28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred			
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.					
29b. Signature and title of certifier 		29c. License number D 50653		29d. Date signed (Month, Day, Year) January 9, 2004	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Gyan C. Surana, M.D. 5851 Deale Churchton Rd., Deale, MD 20751					
31. Date filed (Month, Day, Year) JAN 14 2004		32. Registrar's Signature 			

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

State
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2004 03651

1- For
State
RegistrarPhysician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Charles Arthur Ward, Sr.

2. Date of Death

JAN 6 2004

3. Time of Death

1755 M

4a. Facility Name (If not institution, give street and number)

1508 Hill Street

4b. City, Town, or Location of Death

Lothian

4c. County of Death

AA

Funeral
Director

5. Social Security Number

220-40-5069

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

61 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

April 22, 1942

9. Birthplace (State or Foreign Country)

Virginia

Usual Residence of Decedent

10a. State

Maryland

10b. County

Anne Arundel

10c. City, Town or Location

Lothian

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

1508 Hill Street

10f. Zip Code

20711

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: white

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Garage Door Mechanic

16b. Kind of Business/Industry

self employed

17. Father's Name (First, Middle, Last)

Corbet Lester Ward

18. Mother's Name (First, Middle, Maiden Surname)

Malissa Marie Stallard

19a. Informant's Name/Relationship (Type, Print)

Charles A. Ward, Jr., son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1508 Hill St., Lothian, MD 20711

20a. Method of Disposition

1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☒ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Geo. Washington University 1/7/04 Washington, DC

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

Bryna Rubach

22. Name and Address of Facility

Rausch Funeral Home, P.A. Owings, MD 20736

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Acute Respiratory Failure

Due to (or as a consequence of):

b. Influenza

Due to (or as a consequence of):

c. Chronic Obstructive Pulmonary Disease

Due to (or as a consequence of):

d.

Approximate Interval Between Onset and Death

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☐ No
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy
4 ☐ Pregnant at time of death 5 ☐ Other (specify)
9 ☐ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☒ Yes 2 ☐ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

William P. Jones, MD Deputy

29c. License number

D 06054

29d. Date signed (Month, Day, Year)

1/6/04

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

William P. Jones, MD 695 America Ct. 21035

31. Date filed (Month, Day, Year)

JAN 14 2004

32. Registrar's Signature

Bryna Rubach

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.State
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2004 03652

1- For
State
Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Bettie Jane Wood				2. Date of Death Month Day Year January 6, 2004		3. Time of Death 1845 M	
	4a. Facility Name (If not institution, give street and number) Calvert Memorial Hospital				4b. City, Town, or Location of Death Prince Frederick		4c. County of Death Calvert	
Funeral Director	5. Social Security Number 578-26-4861	6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 78 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) Mar. 21, 1925		9. Birthplace (State or Foreign Country) Washington, D.C.
	Usual Residence of Decedent							
To Be Completed by Funeral Director	10a. State Maryland	10b. County Calvert	10c. City, Town or Location Lusby			10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
	10e. Street and Number 1125 White Sands Drive			10f. Zip Code 20657		10g. Citizen of What Country? USA		
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4or 5+) 2		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Manager		16b. Kind of Business/Industry State Government			
	17. Father's Name (First, Middle, Last) George Frederick Harding				18. Mother's Name (First, Middle, Maiden Surname) Bertha Hausman			
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) Gary R. Wood/Son				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) P.O. Box 1900 Prince Frederick, MD 20678			
	20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input checked="" type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Metrop. Crematory		Date 1/7/2004		20c. Location - City or Town, State Alexandria, VA	
	21. Signature of Funeral Service Licensee Bladys G. Savell				22. Name and Address of Facility Sewell Funeral Home 1451 Dares Beach Rd. Prince Fred., MD 20678			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause in each line. Immediate Cause (Final disease or condition resulting in death) a. Chronic Myelogenous Leukemia Due to (or as a consequence of): b. Severe Thrombocytopenia Due to (or as a consequence of): c. Diabetes Mellitus Due to (or as a consequence of): d. Acute tubular Necrosis							
	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 9 <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 4 <input type="checkbox"/> Pregnant at time of death 9 <input type="checkbox"/> Unknown		3 <input type="checkbox"/> Ectopic pregnancy 5 <input type="checkbox"/> Other (Specify)		23d. Date of delivery Month Day Year	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Atherosclerotic Cardiovascular disease hypothyroidism						23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown		
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No						
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA		26. Place of Death (Check only one) Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)				
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28d. Describe how injury occurred				
28f. Location (Street and Number or Rural Route Number, City or Town, State)								
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
29b. Signature and title of certifier Paul Spurrin				29c. License number D45092		29d. Date signed (Month, Day, Year) 1/6/2004		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 110 Hospital Road Suite 303 Prince Fredrick, MD 20678								
31. Date filed (Month, Day, Year) JAN 08 2004				32. Registrar's Signature Beverly H. Spurrin				

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: if item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Robert Lewis Walker
04-00215
RJ

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2004 03653

1- For State Registrar

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)
Robert Lewis Walker

2. Date of Death
Month Day Year
January 8, 2004

3. Time of Death
0650 P. M

4a. Facility Name (If not institution, give street and number)

5150 Running Deer Place

4b. City, Town, or Location of Death

Hughesville

4c. County of Death

Charles

Funeral
Director

5. Social Security Number
214 50 9990

6. Sex
1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)
54 Yrs.

If Under 1 Year
Months Days

If Under 24 Hrs.
Hours Min.

8. Date of Birth
(Month, Day, Year)
Sept. 16 1949

9. Birthplace (State or Foreign Country)
Maryland

Usual Residence of Decedent

10a. State
Maryland

10b. County
Calvert

10c. City, Town or Location
Port Republic

10d. Inside City Limits
1 ☐ Yes 2 ☒ No

10e. Street and Number
1325 Grays Road

10f. Zip Code
20676

10g. Citizen of What Country?
United States

11. Marital Status
1 ☐ Never Married 2 ☐ Married
3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S.
Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,
Black, White, etc.
Specify: white

15. Decedent's Education
(Specify only highest grade completed)
Elementary/Secondary (0-12) 12
College (1-4 or 5+) College (1-4 or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)
contract scheduler

16b. Kind of Business/Industry
power plant maintenance

17. Father's Name (First, Middle, Last)
George Leonard Walker, Sr.

18. Mother's Name (First, Middle, Maiden Surname)
Audrey Louise Ingle

19a. Informant's Name/Relationship (Type, Print)
Robert L. Walker, Jr. - son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
P.O. Box 233 Millville West Virginia 25432

20a. Method of Disposition
1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of
cemetery, crematory or other place)
Metropolitan Funeral Service

20c. Location - City or Town, State
Alexandria Virginia

21. Signature of Funeral Service Licensee

22. Name and Address of Facility
Rausch Funeral Home PA
4405 Brookes Is. Rd. Port Republic, MD 20676

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.

Immediate Cause (Final
disease or condition
resulting in death)

a. Atherosclerotic Cardiovascular disease

Due to (or as a consequence of):

Sequentially list conditions
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate
Interval Between
Onset and Death

IF FEMALE:

23b. Was decedent pregnant
in the past 12 months?
1 ☐ Yes 2 ☐ No
9 ☐ Unknown

23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown

3 ☐ Ectopic pregnancy
5 ☐ Other (specify)

23d. Date of delivery
Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?
1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an
autopsy
performed?
1 ☒ Yes 2 ☐ No

24b. Were autopsy findings available
prior to completion of cause of
death?
1 ☒ Yes 2 ☐ No

25. Was case referred to medical
examiner?
1 ☒ Yes 2 ☐ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☒ Other (Specify) At scene

27. Manner of Death
1 ☒ Natural 5 ☐ Pending
2 ☐ Accident investigation
3 ☐ Suicide 6 ☐ Could not be
4 ☐ Homicide determined

28a. Date of Injury
(Month, Day Year)

28b. Time of
Injury
M

28c. Injury at
Work?
1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number,
City or Town, State)

29a. Certifier
(Check only
one)

1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number
O.C.M.E.

29d. Date signed (Month, Day, Year)
January 9, 2004

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ZABINULLAH ALI

111 Penn Street, Baltimore, Maryland 21201

31. Date filed (Month, Day, Year)

JAN 12 2004

32. Registrar's Signature

Robert L. Walker

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show
any injury or other traumatic event, the Medical Examiner must be notified at
once.

Physician
/Medical
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

State
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2004 03654

1- For State Registrar

Physician / Medical Examiner
Funeral Director

1. Decedent's Name (First, Middle, Last) Annie Rebecca Wedding		2. Date of Death Month Day Year January 22, 2004		3. Time of Death 11:30 p M	
4a. Facility Name (If not institution, give street and number) Solomons Nursing Center		4b. City, Town, or Location of Death Solomons		4c. County of Death Calvert	
5. Social Security Number 213-40-9010		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 86 Yrs.	
8. Date of Birth (Month, Day, Year) May 3, 1917		9. Birthplace (State or Foreign Country) VA			
Usual Residence of Decedent					
10a. State MD		10b. County Calvert		10c. City, Town or Location Owings	
10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No					
10e. Street and Number 8310 Mt. Harmony Lane		10f. Zip Code 20736		10g. Citizen of What Country? USA	
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:	
14. Race - American Indian, Black, White, etc. Specify: White					
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 3 College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Farmer		16b. Kind of Business/Industry Farming	
17. Father's Name (First, Middle, Last) Pharis Landris Morgal		18. Mother's Name (First, Middle, Maiden Sumame) Carrie Virginia Simpson			
19a. Informant's Name/Relationship (Type, Print) Josephine Flynn/Daughter		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8310 Mt. Harmony Lane, Owings, MD 20736			
20a. Method of Disposition <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input checked="" type="checkbox"/> Donation <input checked="" type="checkbox"/> Other (Specify) entombment		20b. Place of Disposition (Name of cemetery, crematory or other place) S. Memorial Gardens		20c. Location - City or Town, State 1/26/04 Dunkirk, MD	
21. Signature of Funeral Service Licensee 		22. Name and Address of Facility Raymond-Wood F.H., P.A. PO Box 430, Dunkirk, Maryland 20754			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Pneumonia Due to (or as a consequence of): b. Advanced age Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		23b. If FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <input type="checkbox"/> Unknown	
23d. Date of delivery Month Day Year					
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Failure to thrive		23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown			
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M	
28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred			
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.					
29b. Signature and title of certifier G. Blattan, MD		29c. License number 00058572		29d. Date signed (Month, Day, Year) January 23, 2004	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 110 Hospital Rd, Suite 310 Prince Frederick, MD 20678 G. Blattan, M.D					
31. Date filed (Month, Day, Year) JAN 26 2004		32. Registrar's Signature 			

Baltimore, Maryland 21215-0036
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
important: if item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician / Medical Examiner
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Division of Vital Records, P.O. Box 68760,

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2004 03655

1- For State Registrar

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician / Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

1. Decedent's Name (First, Middle, Last) Annie M. Armstead		2. Date of Death Month 2 / Day 3 / Year 04		3. Time of Death 6:45A M	
4a. Facility Name (If not institution, give street and number) Long Green Nursing Home		4b. City, Town, or Location of Death Baltimore		4c. County of Death	
5. Social Security Number 218-36-2739		6. Sex 1 <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 90 Yrs.	
8. Date of Birth (Month, Day, Year) 7/27/13		9. Birthplace (State or Foreign Country) South Carolina			
10a. State MD		10b. County Baltimore		10c. City, Town or Location	
10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		10e. Street and Number 6617 Knottwood Court		10f. Zip Code 21214	
10g. Citizen of What Country? USA		11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:	
13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: Black			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 2 yrs.		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Nurse		16b. Kind of Business/Industry Private	
17. Father's Name (First, Middle, Last) Willie Simpson		18. Mother's Name (First, Middle, Maiden Surname) Agnus Simpson			
19a. Informant's Name/Relationship (Type, Print) Gladys L. Weldon (Daughter)		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6617 Knottwood Court + Balto MD 21214			
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Arbutus Cemetery		20c. Location - City or Town, State 2/9/04 Balto MD	
21. Signature of Funeral Service Licensee Virgin Greene		22. Name and Address of Facility Valley Creek Funeral Services		4405 York Rd. Balto MD 21212	
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Progressive Decline Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Debilitated ulcer Atrial Fibrillation Cerebrovascular Accident					
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 9 <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) 9 <input type="checkbox"/> Unknown		23d. Date of delivery Month Day Year	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Anaemia Degenerative Joint Disease					
23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown					
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No			
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M	
28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	
28f. Location (Street and Number or Rural Route Number, City or Town, State)					
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.					
29b. Signature and title of certifier Dr. [Signature] MD		29c. License number D31464		29d. Date signed (Month, Day, Year) 2/6/04	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SHARIS A. HASHMI MD, 821 N. Entaw St Suite 308 Baltimore MD 21201					
31. Date filed (Month, Day, Year) FEB 10 2004		32. Registrar's Signature [Signature]			

Aron Alston
04-0893
AKG

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend Item #1 per me G829 3/29/04 tas
State of Maryland / Department of Health and Mental Hygiene
Unpend Item #23a, Part II, 27, Per ME, G828 2/13/04 leg
AMEND ITEM #5 PER FH G829 3/04/04 JH

2004 03656

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last) ARON ALSTON		2. Date of Death Month February Day 2 Year 2004		3. Time of Death 3:50 PM		
4a. Facility Name (If not institution, give street and number) MARYLAND GENERAL HOSPITAL		4b. City, Town, or Location of Death BALTIMORE		4c. County of Death		
5. Social Security Number 21-60-1862		6. Sex XX M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 53 Yrs.		
8. Date of Birth (Month, Day, Year) 12/13/1950		9. Birthplace (State or Foreign Country) CHAPEL HILL, NC				
Usual Residence of Decedent						
10a. State MD		10b. County BALTIMORE		10c. City, Town or Location BALTIMORE		
10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No						
10e. Street and Number 1744 FULTON AVENUE		10f. Zip Code 21217		10g. Citizen of What Country? U.S.A.		
11. Marital Status UNK <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		
14. Race - American Indian, Black, White, etc. Specify: BLACK		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4or 5+)				
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) UNK		16b. Kind of Business/Industry UNK				
17. Father's Name (First, Middle, Last) LACY ALSTON			18. Mother's Name (First, Middle, Maiden Surname) ESSIE PUREFOY			
19a. Informant's Name/Relationship (Type, Print) ELVA WRIGHT -- SISTER			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5509 BELAIR ROAD, BALTIMORE, MD 21206			
20a. Method of Disposition <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input checked="" type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) CHAPEL HILL CEM		20c. Location - City or Town, State CHAPEL HILL, NC		
20d. Date FEB 14, 2004						
21. Signature of Funeral Service Licensee KELLY GREGORY FINK #MO1148		22. Name and Address of Facility MARYLAND MORTUARY/ FINK F.H. 426 CRAIN HIGHWAY S., GLEN BURNIE, MD 21061				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Hypertensive Atherosclerotic Cardiovascular Disease Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of):						Approximate Interval Between Onset and Death
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Other (specify)		23d. Date of delivery Month Day Year		
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Chronic Ethanolism						
23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown						
24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No				
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No						
26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		
28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		28d. Describe how injury occurred				
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.						
29b. Signature and title of certifier Auer		29c. License number O.C.M.E.		29d. Date signed (Month, Day, Year) February 3, 2004		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ANA RUBIO, MD 111 Penn Street, Baltimore, Maryland 21201						
31. Date filed (Month, Day, Year) FEB 10 2004		32. Registrar's Signature Benjamin B. Sparks				

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

James R. Alban

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

1- For State Registrar
Unpending Item #23a, Part II, 27, 28a-f, Per ME C828, 2/18/04

State of Maryland / Department of Health and Mental Hygiene

Reg. No.

2004 03657

3132

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial/transit certificate.Physician
/Medical
ExaminerFuneral
Director

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

1. Decedent's Name (First, Middle, Last) James Robert Alban		2. Date of Death Month January Day 24 Year 2004		3. Time of Death 438 a	
4a. Facility Name (If not institution, give street and number) 1404 Shade Tree Road Apt. F		4b. City, Town, or Location of Death Essex		4c. County of Death Baltimore	
5. Social Security Number 449-02-0173		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 50 Yrs.	
8. Date of Birth (Month, Day, Year) March 30, 1953		9. Birthplace (State or Foreign Country) Maryland			
Usual Residence of Decedent					
10a. State Maryland		10b. County Baltimore		10c. City, Town or Location Baltimore	
10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
10e. Street and Number 1170 Boxwood Lane		10f. Zip Code 21221		10g. Citizen of What Country? United States	
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:	
14. Race - American Indian, Black, White, etc. Specify: white					
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) maintenance representative		16b. Kind of Business/Industry computer	
17. Father's Name (First, Middle, Last) Edgar H. Alban		18. Mother's Name (First, Middle, Maiden Surname) Margaret Roth			
19a. Informant's Name/Relationship (Type, Print) Robert L. Alban, Sr./uncle		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2464 E. Ruhl Rd. Freeland, MD 21053			
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Greenmount Crematory		20c. Location - City or Town, State Baltimore, Maryland	
20d. Date Feb. 9, 2004					
21. Signature of Funeral Service Licensee John O. Mitchell IV		22. Name and Address of Facility Mitchell-Wiedefeld Funeral Home, Inc. 6500 York Rd. Baltimore, MD 21212			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Narcotic Intoxication					
23b. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Cause of injury that initiated events resulting in death) Last					
23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <input type="checkbox"/> Unknown					
23d. Date of delivery Month Day Year					
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Cocaine Use, Hypertensive Atherosclerotic Cardiovascular Disease					
23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown					
24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No					
24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No					
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) at scene			
27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input checked="" type="checkbox"/> Could not be determined		28a. Date of Injury found 1/24/04		28b. Time of Injury found 4:20 a	
28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred unknown			
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) found in apartment		28f. Location (Street and Number or Rural Route Number, City or Town, State) 1404 Shade Tree Road, Apt. F Baltimore, MD			
29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.					
29b. Signature and title of certifier Tasha Z Greenberg MD		29c. License number OCME		29d. Date signed (Month, Day, Year) January 24 2004	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Tasha Z Greenberg, M.D. 111 Penn Street, Baltimore, Maryland 21201					
31. Date filed (Month, Day, Year) FEB 10 2004		32. Registrar's Signature Benita B Sparks			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2004 03658

1- For
State
Registrar

Certificate of Death

Reg. No.

Physician
/Medical
ExaminerFuneral
Director

1. Decedent's Name (First, Middle, Last)

Evelyn Brown

2. Date of Death

2/1/04

3. Time of Death

9:10p^M

4a. Facility Name (If not institution, give street and number)

6006 The Alameda

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

5. Social Security Number

241-76-9721

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

61 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

9/29/42

9. Birthplace (State or Foreign Country)

North Carolina

Usual Residence of Decedent

10a. State
MD

10b. County

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

4303 York Road 1st Floor

10f. Zip Code

21212

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4or 5+)

12th

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Daycare Provider Private

16b. Kind of Business/Industry

17. Father's Name (First, Middle, Last)

Henry Tabron

18. Mother's Name (First, Middle, Maiden Surname)

Maggie Floyd Harrison

19a. Informant's Name/Relationship (Type, Print)

Carlton O. Tabron (SON)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

6006 The Alameda Balto MD 21239

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

King Memorial Park 2/7/04 Balto MD

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

Vaughn Greene

22. Name and Address of Facility

Vaughn C Greene Funeral Services
4405 York Rd Balto MD 21212

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. ACUTE M.I.

Due to (or as a consequence of):

b. CARDIOMYOPATHY

Due to (or as a consequence of):

c. CHRONIC RENAL INSUFFICIENCY

Due to (or as a consequence of):

d. S.I.E

Approximate Interval Between Onset and Death

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☒ No9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death4 ☐ Pregnant at time of death9 ☐ Unknown3 ☐ Ectopic pregnancy5 ☐ Other (specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ NoHospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient3 ☒ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Raymond A. Nze

29c. License number

D34184

29d. Date signed (Month, Day, Year)

2/5/04

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

RAYMOND A. NZE MD, PA, 7801 YORK RD #100, TOWSON MD 21264

31. Date filed (Month, Day, Year)

FEB 10 2004

32. Registrar's Signature

[Signature]

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
ExaminerTo the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial/transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

State
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2004 03659

1- For State Registrar

Physician
/Medical
ExaminerFuneral
Director

1. Decedent's Name (First, Middle, Last)

NATHANIEL G. BROOKS

2. Date of Death

February 2 2004

3. Time of Death

1833p^M

4a. Facility Name (If not institution, give street and number)

1200 blk. Ramblewood Road

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

N/A

5. Social Security Number

218-13-8413

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

17 Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

JUNE 10, 1986

9. Birthplace (State or Foreign Country)

MARYLAND

Usual Residence of Decedent

10a. State

MD

10b. County

10c. City, Town or Location

BALTIMORE

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

729 RICHWOOD AVE.

10f. Zip Code

21212

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☒ Never Married 2 ☐ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: BLACK

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4or 5+)

12th

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

STUDENT

16b. Kind of Business/Industry

STUDENT

17. Father's Name (First, Middle, Last)

LEONARD N. BROOKS

18. Mother's Name (First, Middle, Maiden Surname)

CAROLYN A. CLARK

19a. Informant's Name/Relationship (Type, Print)

CAROLYN BROOKS / MOTHER

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

729 RICHWOOD AVE. BALTIMORE, MARYLAND 21212

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

KING MEMORIAL PARK

Date

2-9-04

20c. Location - City or Town, State

BALTIMORE, MARYLAND

21. Signature of Funeral Service Licensee

Vaughn Greene

22. Name and Address of Facility

VAUGHN C. GREENE FUNERAL HOME
1905 YORK ROAD BALTIMORE, MARYLAND 21212

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. MULTIPLE GUNSHOT WOUNDS AND BLUNT FORCE INJURIES

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☐ No9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death4 ☐ Pregnant at time of death9 ☐ Unknown3 ☐ Ectopic pregnancy5 ☐ Other (specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23a. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☒ Yes 2 ☐ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☒ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☒ Yes 2 ☐ No

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☒ Other (Specify)

at scene

27. Manner of Death

1 ☐ Natural2 ☐ Accident3 ☐ Suicide4 ☒ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

2/2/04

28b. Time of Injury

6:33P M

28c. Injury at Work?

1 ☐ Yes 2 ☒ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

STREET

28d. Describe how injury occurred

SUBJECT WAS SHOT AND BEATEN

28f. Location (Street and Number or Rural Route Number, City or Town, State)

1200 BLK. RAMBLEWOOD, BALTIMORE, MD

29a. Certifier (Check only one)

1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Ana Rubio

29c. License number

OCME

29d. Date signed (Month, Day, Year)

February 3 2004

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ANA RUBIO, MD

111 Penn Street, Baltimore, Maryland 21201

31. Date filed (Month, Day, Year)

FEB 10 2004

32. Registrar's Signature

[Signature]

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transitState
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2004 03660

1- For
State
Registrar

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <i>Joseph Blue, Jr.</i>		2. Date of Death Month <i>February</i> Day <i>02</i> Year <i>2004</i>		3. Time of Death <i>10:18 AM</i>
	4a. Facility Name (If not institution, give street and number) <i>ST. Agnes Healthcare</i>		4b. City, Town, or Location of Death <i>Baltimore</i>		4c. County of Death <i>N/A</i>
Funeral Director	5. Social Security Number <i>217 96 6379</i>	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <i>35</i> Yrs.	8. Date of Birth (Month, Day, Year) <i>Sept. 25, 1968</i>	
	9. Birthplace (State or Foreign Country) <i>Maryland</i>		10. Usual Residence of Decedent		
To Be Completed by Funeral Director	10a. State <i>Maryland</i>	10b. County <i>N/A</i>	10c. City, Town or Location <i>Baltimore</i>		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
	10e. Street and Number <i>31 N. Calver Street</i>		10f. Zip Code <i>21229</i>		10g. Citizen of What Country? <i>USA</i>
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:
	14. Race - American Indian, Black, White, etc. Specify: <i>Black</i>		15. Decedent's Education (Specify only highest grade completed) <i>11th grade</i>		
	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <i>Floor Technician</i>		16b. Kind of Business/Industry <i>AT ONCE JANITORIAL SERVICE</i>		
	17. Father's Name (First, Middle, Last) <i>Joseph Blue, Sr.</i>		18. Mother's Name (First, Middle, Maiden Surname) <i>MILDRED Duggs</i>		
	19a. Informant's Name/Relationship (Type, Print) <i>Brenda Blue / wife</i>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>31 N. Calver Street Baltimore Maryland 21229</i>		
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <i>N. L. Zion Cemetery</i>		20c. Location - City or Town, State <i>Baltimore Maryland</i>
	21. Signature of Funeral Service Licensee <i>Henry Jones</i>		22. Name and Address of Facility <i>CHARMAN - Harris Funeral Home 5240 Reisterstown Road Baltimore, Md 21215</i>		
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Cause of death) <i>atherosclerotic cardiovascular disease</i>				
23b. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.					
23c. Date of delivery Month <i>February</i> Day <i>2</i> Year <i>2004</i>					
23d. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown					
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined					
28a. Date of Injury (Month, Day Year) <i>Feb 1 2004</i>					
28b. Time of Injury <i>M</i>					
28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
28d. Describe how injury occurred					
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)					
28f. Location (Street and Number or Rural Route Number, City or Town, State)					
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.					
29b. Signature and title of certifier <i>Joseph Blue, Jr. MD</i>					
29c. License number <i>D33061</i>					
29d. Date signed (Month, Day, Year) <i>February 2, 2004</i>					
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <i>Josephine Savader MD St Agnes Healthcare Baltimore</i>					
31. Date filed (Month, Day, Year) <i>FEB 10 2004</i>					
32. Registrar's Signature <i>James H. Smith</i>					

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural," or item 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?
☐ Yes ☒ No
☐ Unknown

23c. If yes, outcome of pregnancy
☐ Live birth ☐ Fetal death
☐ Ectopic pregnancy
☐ Pregnant at time of death
☐ Other (specify) _____
☐ Unknown

23d. Date of delivery
 Month *February* Day *2* Year *2004*

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?
☒ Yes ☐ No ☐ Probably ☐ Unknown

24a. Was an autopsy performed?
☐ Yes ☒ No

24b. Were autopsy findings available prior to completion of cause of death?
☐ Yes ☒ No

25. Was case referred to medical examiner?
☐ Yes ☒ No

26. Place of Death (Check only one)
 Hospital: ☐ Inpatient ☒ ER/Outpatient ☐ DOA Other: ☐ Nursing Home ☐ Residence ☐ Other (Specify)

27. Manner of Death
☒ Natural ☐ Accident ☐ Suicide ☐ Homicide
☐ Pending investigation ☐ Could not be determined

28a. Date of Injury (Month, Day Year)
Feb 1 2004

28b. Time of Injury
M

28c. Injury at Work?
☐ Yes ☒ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier
 (Check only one)
☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier
Joseph Blue, Jr. MD

29c. License number
D33061

29d. Date signed (Month, Day, Year)
February 2, 2004

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Josephine Savader MD St Agnes Healthcare Baltimore

31. Date filed (Month, Day, Year)
FEB 10 2004

32. Registrar's Signature
James H. Smith

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

1- For State Registrar

2004 03661

ADA - BECKER

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Physician /Medical Examiner

Funeral Director

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last) ADA BECKER		2. Date of Death Month FEBRUARY Day 5 Year 2004		3. Time of Death 5:30 P M	
4a. Facility Name (If not institution, give street and number) NORTH OAKS HEALTH CENTER		4b. City, Town, or Location of Death PIKESVILLE		4c. County of Death BALTIMORE	
5. Social Security Number 217-92-9822	6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 89 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) SEPT. 25, 1914
9. Birthplace (State or Foreign Country) MD					
Usual Residence of Decedent					
10a. State MD	10b. County BALTIMORE	10c. City, Town or Location PIKESVILLE		10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
10e. Street and Number 725 MT. WILSON LANE		10f. Zip Code 21208		10g. Citizen of What Country? U.S.A.	
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:	
14. Race - American Indian, Black, White, etc. Specify: WHITE		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) HOUSEWIFE			
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)		16b. Kind of Business/Industry OWN HOME			
17. Father's Name (First, Middle, Last) HARRY GORELIK		18. Mother's Name (First, Middle, Maiden Surname) JENNIE ERENBURG			
19a. Informant's Name/Relationship (Type, Print) LARRY BECKER / SON		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3621 WOODVALLEY DRIVE - BALTIMORE, MD 21208			
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) BETH TFILOH CEMETERY		20c. Date 2/8/2004	
20d. Location - City or Town, State WOODLAWN, MD		21. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Congestive Heart Failure Due to (or as a consequence of): b. Atherosclerotic Cardiovascular Disease Due to (or as a consequence of): c. Due to (or as a consequence of): d. Approximate Interval Between Onset and Death 2 Days 10 years					
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 9 <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) 9 <input type="checkbox"/> Unknown		23d. Date of delivery Month Day Year	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Hypertension					
23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown					
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No			
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
27. Manner of Death 1 <input type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M	
28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred			
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.					
29b. Signature and title of certifier [Signature]		29c. License number 038675		29d. Date signed (Month, Day, Year) February 5, 2004	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) JOEL MESHULAM 301 ST PAUL PL SUITE 605 BALTIMORE MD 21202					
31. Date filed (Month, Day, Year) FEB 10 2004		32. Registrar's Signature [Signature]			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2004 03662

1- For
State
RegistrarPhysician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Irvin Henry Booker

2. Date of Death

February 4

2004

3. Time of Death

8:40 A. M.

Funeral
Director

4a. Facility Name (If not institution, give street and number)

53 Chesapeake Mobile Court

4b. City, Town, or Location of Death

Hanover

4c. County of Death

Anne Arundel

5. Social Security Number

219 32 2235

6. Sex

1 ☒ M 2 ☐ F

7. Age (in yrs. last birthday)

65

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
May 15, 1938

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Anne Arundel

10c. City, Town or Location

Hanover

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

53 Chesapeake Mobile Court

10f. Zip Code

21076

10g. Citizen of What Country?

U.S.

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☒ Yes 2 ☐ No
If Yes, Give
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: White

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

10

College (1-4 or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Truck Driver

16b. Kind of Business/Industry

Ryder System

17. Father's Name (First, Middle, Last)

Marcus T. Booker

18. Mother's Name (First, Middle, Maiden Sumame)

Violet D. Grimm

19a. Informant's Name/Relationship (Type, Print)

Loretta Booker / wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

53 Chesapeake Mobile Court Hanover, Maryland 21076

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Glen Haven Mem. Park

Date

2/7/2004

20c. Location - City or Town, State

Glen Burnie, Maryland

21. Signature of Funeral Service Licensee

Sharon L. Lippert

22. Name and Address of Facility

Gonce Funeral Service, P.A.

4001 Ritchie Highway

Baltimore, Maryland 21225

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)a. Due to (or as a consequence of):
Lung CancerSequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

Approximate
Interval Between
Onset and Death

10 months

IF FEMALE:

23b. Was decedent pregnant
in the past 12 months?1 ☐ Yes 2 ☐ No
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown3 ☐ Ectopic pregnancy5 ☐ Other (specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown24a. Was an
autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings available
prior to completion of cause of
death?1 ☐ Yes 2 ☒ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☒ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation
2 ☐ Accident 6 ☐ Could not be determined
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury

(Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☒ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
and manner stated.

29b. Signature and title of certifier

Dr. [Signature]

29c. License number

031551

29d. Date signed (Month, Day, Year)

February 5, 2004

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Russell B. [Signature] 305 Hospital Dr, Glen Burnie, Md 21061

31. Date filed (Month, Day, Year)

FEB 10 2004

32. Registrar's Signature

[Signature]

State
Registrar

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or item 23a or 28a-f show
any injury or other traumatic event, the Medical Examiner must be notified at
once.Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar AMEND ITEM #20b PER FH G828 2/10/04 Certificate of Death

Reg. No. 2004 03663

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Reginald Curtis		2. Date of Death Month 02 Day 04 Year 04		3. Time of Death 10:30 AM
	4a. Facility Name (If not institution, give street and number) Good Samaritan Hospital		4b. City, Town, or Location of Death Baltimore		4c. County of Death
Funeral Director	5. Social Security Number 219-72-6761	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 43 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.
	8. Date of Birth (Month, Day, Year) 2-29-1960		9. Birthplace (State or Foreign Country) MARYLAND		
To Be Completed by Funeral Director	10a. State MD		10b. County		10c. City, Town or Location BALTIMORE
	10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		10e. Street and Number 807 BRADHURST ROAD		10f. Zip Code 21212
	10g. Citizen of What Country? U.S.A.		11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:
	13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: BLACK		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4or 5+)
	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) CRANE OPERATOR		16b. Kind of Business/Industry STEEL		
To Be Completed by Physician/Medical Examiner	17. Father's Name (First, Middle, Last) WILSON CURTIS		18. Mother's Name (First, Middle, Maiden Surname) NOVELLA BRUNSON		
	19a. Informant's Name/Relationship (Type, Print) KAREN T. CURTIS / WIFE		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 807 BRADHURST ROAD BALTO, MD 21212		
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of Institution or other place) KING MEMORIAL PARK		20c. Location - City or Town, State BALTIMORE, MARYLAND
	21. Signature of Funeral Service Licensee Vaughn C. Greene		22. Name and Address of Facility VAUGHN C. GREENE FUNERAL HOME 4905 YORK ROAD BALTIMORE, MARYLAND 21212		
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) End-stage Renal Disease Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last HIV/AIDS Sepsis		Approximate Interval Between Onset and Death		
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify)		23d. Date of delivery Month Day Year	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown	
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	
28f. Location (Street and Number or Rural Route Number, City or Town, State)		29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.			
29b. Signature and title of certifier H Patel, MD		29c. License number D0059411		29d. Date signed (Month, Day, Year) 02/04/04	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Hema Patel, MD, 5601 Loch Raven Blvd. Baltimore, MD					
31. Date filed (Month, Day, Year) FEB 10 2004		32. Registrar's Signature [Signature] 21239			

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2004 03664

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) MARION ELIZABETH COLLINS						2. Date of Death Month Day Year February 9, 2004 5:30 AM		3. Time of Death				
	4a. Facility Name (If not institution, give street and number) Charlestown						4b. City, Town, or Location of Death Catonsville		4c. County of Death Baltimore				
Funeral Director	5. Social Security Number 009-32-4966		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 97 Yrs.		8. Date of Birth (Month, Day, Year) 1/19/1907		9. Birthplace (State or Foreign Country) Winsted, CT				
	Usual Residence of Decedent												
10a. State MD		10b. County BALTIMORE		10c. City, Town or Location CATONSVILLE				10d. Inside City Limits 1 <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
10e. Street and Number 709 MAIDEN CHOICE LANE, 1S				10f. Zip Code 21228		10g. Citizen of What Country? USA							
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: WHITE						
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4or 5+) librarian				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) librarian			16b. Kind of Business/Industry VT Free Public Library						
17. Father's Name (First, Middle, Last) CHARLES FOSKETT						18. Mother's Name (First, Middle, Maiden Surname) GERTRUDE GATTER							
19a. Informant's Name/Relationship (Type, Print) CHRISTOPHER R. COLLINS - SON						19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 788 LOCUST CIRCLE, ARNOLD, MD 21012							
20a. Method of Disposition <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input checked="" type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) GREEN MOUNTAIN CEMETERY		Date UNK		20c. Location - City or Town, State MONTPELLIER, VT					
21. Signature of Funeral Service Licensee KELLY GREGORY FINK #MO1148				22. Name and Address of Facility FINK FUNERAL HOME, PA 426 CRAIN HIGHWAY S., GLEN BURNIE, MD 21061									
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Atherosclerotic heart + disease Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last										Approximate Interval Between Onset and Death years			
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.										23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown			
										24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)									
27. Manner of Death 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide				28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred			
				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)					
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.													
29b. Signature and title of certifier Phillip Stone, MD				29c. License number D47009		29d. Date signed (Month, Day, Year) February 9, 2004							
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Phillip Stone, 711 Maiden Choice Lane, Baltimore, MD 21228													
31. Date filed (Month, Day, Year) FEB 10 2004				32. Registrar's Signature Benita B. Sparks									

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: if item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2004 03665

1- For State Registrar

Physician / Medical Examiner	1. Decedent's Name (First, Middle, Last) Linwood Albert Curtis				2. Date of Death Month FEB. Day 3, Year 2004		3. Time of Death 0719 A^M	
	4a. Facility Name (If not institution, give street and number) 1808 NORTH DUKELAND STREET				4b. City, Town, or Location of Death BALTIMORE CITY		4c. County of Death N/A	
Funeral Director	5. Social Security Number 217-76-9898		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 45 Yrs.		8. Date of Birth (Month, Day, Year) 8-9-58	
	9. Birthplace (State or Foreign Country) Baltimore, Md.		10a. State Md.		10b. County N/A		10c. City, Town or Location Baltimore	
To Be Completed by Funeral Director	10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No				10e. Street and Number 1808 N. Dukeland St.		10f. Zip Code 21216	
	10g. Citizen of What Country? USA				11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:	
To Be Completed by Physician/Medical Examiner	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: Black		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+)	
	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Construction Worker				16b. Kind of Business/Industry Construction Co.			
To Be Completed by Physician/Medical Examiner	17. Father's Name (First, Middle, Last) Edward N. Curtis Sr.				18. Mother's Name (First, Middle, Maiden Surname) Inez Curtis			
	19a. Informant's Name/Relationship (Type, Print) Inez Curtis Mother				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1808 N. Dukeland St, Baltimore, Md. 21216			
To Be Completed by Physician/Medical Examiner	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Mt. Zion Cem.		20c. Location - City or Town, State 2-10-04 Lansdowne, Md.	
	21. Signature of Funeral Service Licensee Lloyd M. Estep				22. Name and Address of Facility Estep Brothers Funeral Ser, P.A. 1300 Eutaw Place, Baltimore, Md. 21217			
To Be Completed by Physician/Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. LIVER CIRRHOSIS Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of):				Approximate Interval Between Onset and Death			
	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown				23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <input type="checkbox"/> Unknown			
To Be Completed by Physician/Medical Examiner	23d. Date of delivery Month Day Year				24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
	24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				24c. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown			
To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) AT SCENE			
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined				28a. Date of Injury (Month, Day Year) 28b. Time of Injury M 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No 28d. Describe how injury occurred 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)			
To Be Completed by Physician/Medical Examiner	29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. Signature and title of certifier Aue D			
	29c. License number O.C.M.E				29d. Date signed (Month, Day, Year) FEB. 3, 2004			
To Be Completed by Physician/Medical Examiner	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ANA RUBIO, MD 111 Penn Street, Baltimore, Maryland 21201				31. Date filed (Month, Day, Year) FEB 10 2004			
	32. Registrar's Signature Benjamin G. [Signature]							

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at 9088.

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2004 03666

1- For
State
Registrar

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Lee E. Coe				2. Date of Death Month 2 Day 1 Year 04		3. Time of Death 5:30 PM	
	4a. Facility Name (If not institution, give street and number) Future Care Cherry Wood				4b. City, Town, or Location of Death Reisterstown		4c. County of Death Baltimore Co	
Funeral Director	5. Social Security Number 247-54-5028	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 68 Yrs.	If Under 1 Year Months	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) 12-16-35	9. Birthplace (State or Foreign Country) S. Carolina	
	Usual Residence of Decedent							
To Be Completed by Funeral Director	10a. State Md.	10b. County Baltimore	10c. City, Town or Location Woodlawn (Baltimore)			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
	10e. Street and Number 6641 Dalton Dr.			10f. Zip Code 21207		10g. Citizen of What Country? USA		
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: Black	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4or 5+) College		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Carlos Glass Co		16b. Kind of Business/Industry Glass Co.			
To Be Completed by Physician/Medical Examiner	17. Father's Name (First, Middle, Last) Ed. Coe			18. Mother's Name (First, Middle, Maiden Surname) Eunice Mae Bradford				
	19a. Informant's Name/Relationship (Type, Print) Betty Coe Wife			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6641 Dalton Dr, Baltimore, Maryland 21207				
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Western Cem.		20c. Location - City or Town, State 2-6-04 Baltimore, Md.			
	21. Signature of Funeral Service Licensee Lloyd M. Estep		22. Name and Address of Facility Estep Brothers Funeral Ser, P.A. 1300 Eutaw Place, Baltimore, Md. 21217					
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Vascular Dementia						Approximate Interval Between Onset and Death	
	23a. Part II. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last							
	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown						23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <input type="checkbox"/> Unknown	
	23d. Date of delivery Month Day Year							
To Be Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown	
	24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No						24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
28d. Describe how injury occurred						28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)	
State Registrar	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
	29b. Signature and title of certifier Raymond Miller MD			29c. License number D47683		29d. Date signed (Month, Day, Year) 2/3/04		
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Raymond Miller 25 Main Street Suite 200 Reisterstown MD							
31. Date filed (Month, Day, Year) FEB 10 2004							32. Registrar's Signature [Signature]	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2004 03667

1- For State Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) JAMES E COLTER		2. Date of Death Month FEBRUARY Day 1 Year 2004		3. Time of Death 12:10AM
	4a. Facility Name (If not institution, give street and number) Northwest Hospital		4b. City, Town, or Location of Death Randallstown		4c. County of Death Baltimore
Funeral Director	5. Social Security Number 216-36-3248	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 62 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.
	8. Date of Birth (Month, Day, Year) Feb. 25 1941		9. Birthplace (State or Foreign Country) North Carolina		
Usual Residence of Decedent					
10a. State MD		10b. County N/A		10c. City, Town or Location Baltimore	
10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No					
10e. Street and Number 4523 Mannasota Avenue			10f. Zip Code 21206		10g. Citizen of What Country? USA
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:	
14. Race - American Indian, Black, White, etc. Specify: Black					
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Custodial Engineer		16b. Kind of Business/Industry Baltimore Public School System	
17. Father's Name (First, Middle, Last) James Morris			18. Mother's Name (First, Middle, Maiden Surname) Annie Colter		
19a. Informant's Name/Relationship (Type, Print) Annie Colter Morris - Mother		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2803 Violet Avenue, Baltimore, Maryland 21215			
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Mt. Carmel Cemetery		20c. Location - City or Town, State Baltimore, Maryland	
21. Signature of Funeral Service Licensee Wise		22. Name and Address of Facility Wise Funeral Services, P.A. 700 S. Beechfield Avenue, Baltimore, MD 21229			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.					
Immediate Cause (Final disease or condition resulting in death) SEPTICEMIA					
Due to (or as a consequence of):					
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last PNEUMONIA					
Due to (or as a consequence of):					
myelodysplastic Syndrome					
Due to (or as a consequence of):					
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown					
23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <input type="checkbox"/> Unknown					
23d. Date of delivery Month Day Year					
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.					
23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown					
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M	
28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred			
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.					
29b. Signature and title of certifier Dr. [Signature]		29c. License number D43977		29d. Date signed (Month, Day, Year) February 1 2004	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Angela [Signature] - 301 [Address] [City], [State] [Zip]					
31. Date filed (Month, Day, Year) FEB 10 2004		32. Registrar's Signature [Signature]			

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2004 03668

1- For
State
RegistrarPhysician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Alice Manning Colgan

2. Date of Death

February 6, 2004

3. Time of Death

3:25P M

Funeral
Director

4a. Facility Name (If not institution, give street and number)

Oakcrest Care Center

4b. City, Town, or Location of Death

Parkville

4c. County of Death

Baltimore

5. Social Security Number

214-14-8634

6. Sex

1 ☐ M ☒ F

7. Age (In yrs. last birthday)

101

Yrs.

If Under 1 Year

Months

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

June 8, 1902

9. Birthplace (State or Foreign Country)

Ohio

Usual Residence of Decedent

10a. State

Maryland

10b. County

Baltimore

10c. City, Town or Location

Parkville

10d. Inside City Limits

1 ☐ Yes 2 ☒ No XXX

10e. Street and Number

8800 Walther Blvd

10f. Zip Code

21234

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

5+

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Teacher

16b. Kind of Business/Industry

Education

17. Father's Name (First, Middle, Last)

Walter Pierce Manning

18. Mother's Name (First, Middle, Maiden Surname)

Cynthia Mary White

19a. Informant's Name/Relationship (Type, Print)

Elaine M Cook

POA

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

3508 Hampstead Mexico Road Hampstead Md 21074

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

St John's Cemetery

Date

2/9/04

20c. Location - City or Town, State

Hydes, Maryland

21. Signature of Funeral Service Licensee

Anne Slesha Kenak

22. Name and Address of Facility

Mitchell-Wiedefeld Funeral Home Inc. 6500 York Road Baltimore, Maryland 21212

23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. ASCVD

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death
20 yrs

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☒ No9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death4 ☐ Pregnant at time of death9 ☐ Unknown3 ☐ Ectopic pregnancy5 ☐ Other (specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Chronic bronchitis

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death Check only one

Other: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

William M. Russell

29c. License number

D30182

29d. Date signed (Month, Day, Year)

February 7, 2004

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

William M. Russell MD 8800 Walther Blvd Baltimore MD 21234

31. Date filed (Month, Day, Year)

FEB 10 2004

32. Registrar's Signature

Anne Slesha Kenak

State
Registrar

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2004 03669

1- For
State
RegistrarPhysician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Peggy J. Dear

2. Date of Death

Month Day Year
FEBRUARY 6, 2004

3. Time of Death

7:30 PM

4a. Facility Name (If not institution, give street and number)

Saint Joseph Medical Center

4b. City, Town, or Location of Death

Towson

4c. County of Death

Baltimore

Funeral
Director

5. Social Security Number

220-24-7718

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

75 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
June 20, 1928

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Baltimore

10c. City, Town or Location

Catonsville

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

4 Rumford Drive Unit 101

10f. Zip Code

21228

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give

Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: White

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

Carville Earle Viers, Sr.

18. Mother's Name (First, Middle, Maiden Surname)

Anna Dorothy Lay

19a. Informant's Name/Relationship (Type, Print)

Robert Dear (Son)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

9804 Old Mill Road Ellicott City, MD 21042

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Loudon Park Cemetery

Date

2-10-2004

20c. Location - City or Town, State

Baltimore, Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Witzke Funeral Home of Catonsville, Inc.
1630 Edmondson Avenue Catonsville, Maryland 21228

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate
Interval Between
Onset and DeathImmediate Cause (Final
disease or condition
resulting in death)

PNEUMONIA

a. Due to (or as a consequence of):

CORONARY ARTERY BYPASS SURGERY

b. Due to (or as a consequence of):

CORONARY ARTERY DISEASE

c. Due to (or as a consequence of):

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

IF FEMALE:

23b. Was decedent pregnant
in the past 12 months?1 ☐ Yes 2 ☒ No9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death4 ☐ Pregnant at time of death9 ☐ Unknown3 ☐ Ectopic pregnancy5 ☐ Other (Specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

HEPARIN INDUCED THROMBOCYTOPENIA

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an
autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings available
prior to completion of cause of
death?1 ☐ Yes 2 ☐ No

25. Was case referred to medical

examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending

investigation

6 ☐ Could not be

determined

28a. Date of Injury

(Month, Day Year)

28b. Time of

Injury

28c. Injury at

Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number

D 30263

29d. Date signed (Month, Day, Year)

02-06-04

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

FRANCIS KHOO M.D. 7601 OSLER DRIVE TOWSON, MARYLAND 21204-7582

31. Date filed (Month, Day, Year)

FEB 10 2004

32. Registrar's Signature

State
Registrar

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show
any injury or other traumatic event, the Medical Examiner must be notified at
once.To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2004 03670

1- For
State
RegistrarPhysician
/Medical
ExaminerFuneral
Director

1. Decedent's Name (First, Middle, Last) Agnes Irene Dorning				2. Date of Death Month Day Year February 6, 2004		3. Time of Death 2:02 am	
4a. Facility Name (If not institution, give street and number) 6114 Tamar Drive				4b. City, Town, or Location of Death Columbia		4c. County of Death Howard County	
5. Social Security Number 184020-6484		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 83 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) April 22, 1920	
9. Birthplace (State or Foreign Country) New York							
Usual Residence of Decedent							
10a. State Maryland		10b. County Howard		10c. City, Town or Location Columbia		10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
10e. Street and Number 6114 Tamar Drive				10f. Zip Code 21045		10g. Citizen of What Country? U.S.A.	
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 8th Grade College (1-4 or 5+) N/A				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker		16b. Kind of Business/Industry Her own home	
17. Father's Name (First, Middle, Last) Balazs Farkas				18. Mother's Name (First, Middle, Maiden Surname) Julia Kovach			
19a. Informant's Name/Relationship (Type, Print) Eileen V. Doyle (Daughter)				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6114 Tamar Drive Columbia, MD 21045			
20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Mt. Comfort Crematory		Date 2/7/04		20c. Location - City or Town, State Alexandria, Virginia	
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility Witzke Funeral Homes, Inc. 5555 Twin Knolls Road Columbia, MD 21045			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) cerebral vascular accident Due to (or as a consequence of): a. advanced arteriosclerosis Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Approximate Interval Between Onset and Death 1 week 20 years							23b. If FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 9 <input type="checkbox"/> Unknown
23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 4 <input type="checkbox"/> Pregnant at time of death 9 <input type="checkbox"/> Unknown							23d. Date of delivery Month Day Year
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. non insulin dependent diabetes mellitus							23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No							24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
28d. Describe how injury occurred				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			
28f. Location (Street and Number or Rural Route Number, City or Town, State)							
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.							
29b. Signature and title of certifier 				29c. License number D26621		29d. Date signed (Month, Day, Year) February 6, 2004	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) GARY MILLER MD 10700 CHARTER DRIVE, COLUMBIA, MD							
31. Date filed (Month, Day, Year) FEB 10 2004				32. Registrar's Signature 			

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2004 03671

1- For
State
RegistrarPhysician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

GRACE DOUGHERTY

2. Date of Death

Month Day Year
FEB 05 2004 2:40 P M

3. Time of Death

Funeral
Director

4a. Facility Name (If not institution, give street and number)

Millennium Health of Ellicott City

4b. City, Town, or Location of Death

ELLICOTT CITY

4c. County of Death

Howard

5. Social Security Number

220-24-5837

6. Sex

☐ M ☒ F

7. Age (In yrs. last birthday)

92 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
Aug 5, 1911

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Howard

10c. City, Town or Location

Elkridge

10d. Inside City Limits

☐ Yes ☒ No

10e. Street and Number

6400 Beechfield Avenue

10f. Zip Code

21075

10g. Citizen of What Country?

U.S.A.

11. Marital Status

☐ Never Married ☐ Married
☒ Widowed ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

☐ Yes ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

☐ Yes ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

8

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

Samuel Birely

18. Mother's Name (First, Middle, Maiden Surname)

Annie Trieschman

19a. Informant's Name/Relationship (Type, Print)

Grace Hickey (Daughter)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

6400 Beechfield Ave. Elkridge, Maryland 21075

20a. Method of Disposition

☒ Burial ☐ Cremation ☐ Removal from State
☐ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Meadowridge

Date

2-9-2004

20c. Location - City or Town, State

Elkridge, Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Witzke Funeral Home, Inc.
5555 Twin Knolls Road Columbia, Maryland 21045

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

CEREBRAL THROMBOSIS

Approximate Interval Between Onset and Death

a. Due to (or as a consequence of):

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

☐ Yes ☒ No
☐ Unknown

23c. If yes, outcome of pregnancy

☐ Live birth ☐ Fetal death ☐ Ectopic pregnancy
☐ Pregnant at time of death ☐ Other (specify)
☐ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

☐ Yes ☒ No ☐ Probably ☐ Unknown

24a. Was an autopsy performed?

☐ Yes ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

☐ Yes ☒ No

25. Was case referred to medical examiner?

☐ Yes ☒ No

Hospital:

☐ Inpatient ☐ ER/Outpatient ☐ DOA

Other:

☒ Nursing Home ☐ Residence ☐ Other (Specify)

27. Manner of Death

☒ Natural ☐ Pending investigation
☐ Accident ☐ Could not be determined
☐ Suicide ☐ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

☐ Yes ☒ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number

D28795

29d. Date signed (Month, Day, Year)

2/6/04

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

TASNEEM CAKHAM, 7220 PARK HEIGHTS AVE BALTO MD 21206

State Registrar

31. Date filed (Month, Day, Year)

FEB 10 2004

32. Registrar's Signature

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23e or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2004 03672

1- For
State
Registrar

Physician
/Medical
Examiner

Funeral
Director

1. Decedent's Name (First, Middle, Last)

Kelly Dillon

2. Date of Death

January 28, 2004

3. Time of Death

5:51 P^M

4a. Facility Name (If not institution, give street and number)

200 block North Amity Street

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

NIA

5. Social Security Number

218-82-2159

6. Sex

1 ☒ M 2 ☐ F

7. Age (in yrs. last birthday)

37 Yrs.

8. Date of Birth

Dec. 15, 1966

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

MD

10b. County

NIA

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

943 W. Lexington St.

10f. Zip Code

21223

10g. Citizen of What Country?

USA

11. Marital Status

1 ☒ Never Married 2 ☐ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12) College (1-4or 5+)
10th

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Warehouseman

16b. Kind of Business/Industry

Factory

17. Father's Name (First, Middle, Last)

Marshall S. Hendricks

18. Mother's Name (First, Middle, Maiden Surname)

Loretta Dillon

19a. Informant's Name/Relationship (Type, Print)

Loretta Dillon - mother

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

943 W. Lexington St. Balto., MD 21223

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Mt. Carmel Cemetery 2-16-04 Dundalk, MD

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

[Signature]

22. Name and Address of Facility

Gary P. March F/H 270 Fred Hilton Pass Balto., MD 21229

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Multiple gunshot wounds

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy
4 ☐ Pregnant at time of death 5 ☐ Other (Specify)
9 ☐ Unknown

23d. Date of delivery
Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?
1 ☒ Yes 2 ☐ No

24b. Were autopsy findings available prior to completion of cause of death?
1 ☒ Yes 2 ☐ No

25. Was case referred to medical examiner?
1 ☒ Yes 2 ☐ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☒ Other (Specify) At scene

27. Manner of Death

1 ☐ Natural 5 ☐ Pending investigation
2 ☐ Accident 6 ☐ Could not be determined
3 ☐ Suicide 4 ☒ Homicide

28a. Date of Injury (Month, Day Year)

Jan 28, 2004

28b. Time of Injury

5:44 PM

28c. Injury at Work?

1 ☐ Yes 2 ☒ No

28d. Describe how injury occurred

Subject was shot

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Alley

28f. Location (Street and Number or Rural Route Number, City or Town, State)

200 Block N. Amity St Baltimore, MD

29a. Certifier (Check only one)

1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Tasha Z Greenberg MD

29c. License number

O.C.M.E.

29d. Date signed (Month, Day, Year)

January 29, 2004

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Tasha Z Greenberg M.D.

111 Penn Street, Baltimore, Maryland 21201

31. Date filed (Month, Day, Year)

FEB 10 2004

32. Registrar's Signature

[Signature]

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2004 03673

Certificate of Death

Reg. No.

1- For State Registrar

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Physician /Medical Examiner

Funeral Director

To Be Completed by Funeral Director

Medical Certification; To Be Completed by Physician/Medical Examiner

1. Decedent's Name (First, Middle, Last) Jenny Dickey		2. Date of Death Month February Day 02 Year 2004		3. Time of Death 2:05 P M	
4a. Facility Name (If not institution, give street and number) The Johns Hopkins Hospital		4b. City, Town, or Location of Death Baltimore City		4c. County of Death	
5. Social Security Number 213-28-5490		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 72 Yrs.	
8. Date of Birth (Month, Day, Year) 1-31-1932		9. Birthplace (State or Foreign Country) MARYLAND			
Usual Residence of Decedent					
10a. State MD		10b. County		10c. City, Town or Location BALTIMORE	
10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		10e. Street and Number 1001 N. BOND STREET		10f. Zip Code 21205	
10g. Citizen of What Country? U.S.A.		11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:	
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: BLACK			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 8 College (1-4or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) HOUSEKEEPER		16b. Kind of Business/Industry HOSPITAL	
17. Father's Name (First, Middle, Last) WILLIAM PURNELL		18. Mother's Name (First, Middle, Maiden Surname) GERTRUDE COLEMAN			
19a. Informant's Name/Relationship (Type, Print) PAULETTE BURRELL/DAUGHTER		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4142 CRADDOCK AVE. BALTO, MD 21212			
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematorium or other place) OAKLAWN CEMETERY		20c. Location - City or Town, State 2-6-04 BALTIMORE MARYLAND	
21. Signature of Funeral Service Licensee Deanna Greene		22. Name and Address of Facility VAUGHN C. GREENE FUNERAL HOME 4405 YORK ROAD BALTIMORE, MD 21212			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. ANOXIC Brain Injury Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Sexually list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last					
Approximate Interval Between Onset and Death Nine Days					
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Unknown		23d. Date of delivery Month Day Year	
23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown					
24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No					
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. End Stage Renal Disease Coronary Artery Disease Hypertension					
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M <input type="checkbox"/> Yes <input type="checkbox"/> No	
28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	
28f. Location (Street and Number or Rural Route Number, City or Town, State)					
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.					
29b. Signature and title of certifier Telly M. Medical Examiner		29c. License number RES-000		29d. Date signed (Month, Day, Year) February 02, 2004	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Telly Ali Meadows The Johns Hopkins Hospital 600 N Wolfe St. Baltimore, MD 21287					
31. Date filed (Month, Day, Year) FEB 10 2004		32. Registrar's Signature [Signature]			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

1- For
State
Registrar

2004 03674

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) VINCENT DIMAGGIO		2. Date of Death Month Day Year FEBRUARY 6, 2004		3. Time of Death 0715 M
	4a. Facility Name (If not institution, give street and number) HERITAGE HARBOR REHABILITATION CTR		4b. City, Town, or Location of Death Annapolis		4c. County of Death ANNE ARUNDEL
Funeral Director	5. Social Security Number 062-16-0732	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 91 Yrs.	8. Date of Birth (Month, Day, Year) JAN 27, 1913	
	9. Birthplace (State or Foreign Country) SICILY, ITALY				
To Be Completed by Funeral Director	10a. State MD		10b. County ANNE ARUNDEL		10c. City, Town or Location CROFTON
	10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No				
	10e. Street and Number 1603 EARLHAM AVE		10f. Zip Code 21114		10g. Citizen of What Country? USA
	11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: XX		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: XX
	14. Race - American Indian, Black, White, etc. Specify: WHITE				
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 8 College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) TRUCK DRIVER		16b. Kind of Business/Industry TRANSPORTATION
	17. Father's Name (First, Middle, Last) GERIAMOLO DiMAGGIO		18. Mother's Name (First, Middle, Maiden Surname) GRACE PUGLISI		
	19a. Informant's Name/Relationship (Type, Print) JEROME A. DiMAGGIO		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1603 EARLHAM AVE. CROFTON MD. 21114		
	20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) PINELAWN MEM. PK.		Date 2/10/2004
	20c. Location - City or Town, State WELLWOOD, NY				
21. Signature of Funeral Service Licensee <i>[Signature]</i>		22. Name and Address of Facility FINK FUNERAL HOME, PA 426 CRAIN HWY., S, GLEN BURNIE, MD 21061			
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Aspiration Pneumonia				Approximate Interval Between Onset and Death 1 wk
	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last				
	a. Due to (or as a consequence of):				
	b. Due to (or as a consequence of):				
	c. Due to (or as a consequence of):				
	d. Due to (or as a consequence of):				
	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown				23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Other (specify) <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <input type="checkbox"/> Unknown
	23d. Date of delivery Month Day Year				
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown
	24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M	
28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred			
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.					
29b. Signature and title of certifier <i>[Signature]</i> Ag J Sprague, MD		29c. License number 032036		29d. Date signed (Month, Day, Year) 2/7/2004	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Gary J Sprague 2108 McDonald Drive Chester, MD 21619					
31. Date filed (Month, Day, Year) FEB 10 2004		32. Registrar's Signature <i>[Signature]</i>			

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2004 03675

1- For
State
RegistrarPhysician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Harry Lee Davis

2. Date of Death

February 3, 2004

3. Time of Death

10:40 P M

Funeral
Director

4a. Facility Name (If not institution, give street and number)

Magnolia Center

4b. City, Town, or Location of Death

Lanham

4c. County of Death

Prince George

5. Social Security Number

246-38-7306

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

75

If Under 1 Year

Months

If Under 24 Hrs.

Hours

8. Date of Birth

(Month, Day, Year)

May 25, 1928

9. Birthplace (State or Foreign Country)

North Carolina

Usual Residence of Decedent

10a. State

10b. County

10c. City, Town or Location

Washington, D.C.

10d. Inside City Limits

☒ Yes 2 ☐ No

10e. Street and Number

3719 30th Place, NE

10f. Zip Code

20018

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☒ Yes 2 ☐ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4or 5+)

12

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Maintenance

16b. Kind of Business/Industry

Montgomery County Public School

17. Father's Name (First, Middle, Last)

Tom Davis

18. Mother's Name (First, Middle, Maiden Surname)

Annie Russ

19a. Informant's Name/Relationship (Type, Print)

Margaret Davis/Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

3719 30th Pl., NE, Washington, D.C. 20018

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Fort Lincoln Cemetery

Date

2-10-2004

20c. Location - City or Town, State

Brentwood, Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Fort Lincoln Funeral Home

3401 Bladensburg Rd., Brentwood, MD 20722

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Lung Carcinoma

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☒ No
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy
4 ☐ Pregnant at time of death 5 ☐ Other (specify)
9 ☐ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D48077

29d. Date signed (Month, Day, Year)

2/15/04

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ALEXANDER E. J. UKOBI, MD
7676 New Hampshire Avenue #210, Takoma Park MD 20912

31. Date filed (Month, Day, Year)

FEB 10 2004

32. Registrar's Signature

[Signature]

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

1- For amend Item 27, per State Registrar **State of Maryland / Department of Health and Mental Hygiene** **Certificate of Death** **Reg. No.** **2004 03676**

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Ruth Edwards			2. Date of Death Month January Day 26 Year 2004		3. Time of Death 1047A M	
	4a. Facility Name (If not institution, give street and number) Northwest Hospital Center			4b. City, Town, or Location of Death Randallstown		4c. County of Death Baltimore	
Funeral Director	5. Social Security Number 215-14-9185	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 81 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) 05/07/1922	9. Birthplace (State or Foreign Country) MD
	Usual Residence of Decedent						
To Be Completed by Funeral Director	10a. State MD	10b. County Baltimore	10c. City, Town or Location Woodstock			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	10e. Street and Number 9801 Slalom Run Drive			10f. Zip Code 21163		10g. Citizen of What Country? USA	
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: Black
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12th College (1-4or 5+) 6yrs		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Probation officer		16b. Kind of Business/Industry St of MD		
	17. Father's Name (First, Middle, Last) Julius Reggie			18. Mother's Name (First, Middle, Maiden Surname) Pauline Young			
Physician /Medical Examiner	19a. Informant's Name/Relationship (Type, Print) Joyce Ann McNeill			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9801 Slalom Run Dr. Woodstock, MD 21163			
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) King Park		Date 2/2/2004		20c. Location - City or Town, State Randallstown, MD
	21. Signature of Funeral Service Licensee Vaughn C. Greene			22. Name and Address of Facility Vaughn C. Greene Funeral Svc. 8728 Liberty Rd. Randallstown, MD 21133			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Gastrointestinal Bleed Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last						Approximate Interval Between Onset and Death
	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Unknown		23d. Date of delivery Month Day Year		
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown	
Medical Certification: To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)				
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
	28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				
	28f. Location (Street and Number or Rural Route Number, City or Town, State)		28g. Location (Street and Number or Rural Route Number, City or Town, State)				
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.						
State Registrar	29b. Signature and title of certifier Maryjoy Melia MD			29c. License number 00060567		29d. Date signed (Month, Day, Year) January 26, 2004	
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Maryjoy Melia, MD Northwest Hospital Center Old Court Road Randallstown, Maryland						
31. Date filed (Month, Day, Year) FEB 10 2004		32. Registrar's Signature [Signature]					

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2004 03677

1- For
State
RegistrarPhysician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

CLIFTON E. EUBANKS

2. Date of Death

FEBRUARY 7, 2004

3. Time of Death

1:08 PM

4a. Facility Name (If not institution, give street and number)

SINAI HOSPITAL

4b. City, Town, or Location of Death

BALTIMORE

4c. County of Death

MD

Funeral
Director

5. Social Security Number

153-38-5512

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

54 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

1-24-50

9. Birthplace (State or Foreign Country)

MD

Usual Residence of Decedent

10a. State
MD

10b. County

10c. City, Town or Location

BALTmore

10d. Inside City Limits

1 ☐ Yes 2 ☐ No

10e. Street and Number

3025 OAKHILL AVE

10f. Zip Code

21207

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☒ Yes 2 ☐ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: BLACK

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12*

College (1-4 or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired)

Maintenance

16b. Kind of Business/Industry

Nursing Home

17. Father's Name (First, Middle, Last)

CLIFTON E. EUBANKS SR.

18. Mother's Name (First, Middle, Maiden Surname)

ARETHA

19a. Informant's Name/Relationship (Type, Print)

YVONNE E. EUBANKS

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

3025 OAKHILL AVE BALTIMORE, MD 21207

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

ARBUS CEMETERY

Date

2-13-04

20c. Location - City or Town, State

BALTIMORE, MD

21. Signature of Funeral Service Licensee

Vaughn C Greene

22. Name and Address of Facility

Vaughn C Greene Funeral Services

8728 Liberty Rd Randallstown, MD 21133

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. NON-SMALL CELL LUNG CANCER

Due to (or as a consequence of):

Approximate Interval Between Onset and Death
7 MONTHS

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. METASTASES TO THE BRAIN

Due to (or as a consequence of):

2 MONTHS

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☐ No9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death4 ☐ Pregnant at time of death9 ☐ Unknown3 ☐ Ectopic pregnancy5 ☐ Other (specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

CONGESTIVE HEART FAILURE

23e. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☒ Yes 2 ☐ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☒ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☒ Yes 2 ☐ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation2 ☐ Accident 6 ☐ Could not be determined3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

DAVID DE LORENZO D.O.

29c. License number

RES0000

29d. Date signed (Month, Day, Year)

FEBRUARY 7, 2004

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DAVID DE LORENZO D.O. SINAI HOSPITAL OF BALTIMORE

31. Date filed (Month, Day, Year)

FEB 10 2004

32. Registrar's Signature

State
Registrar

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2004 03678

1- For
State
RegistrarPhysician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Russell Lee Elliott

2. Date of Death
Month Day Year
February 7, 20043. Time of Death
12:30P^M

4a. Facility Name (If not institution, give street and number)

2203 Stryker Court

4b. City, Town, or Location of Death

Timonium

4c. County of Death

Baltimore

Funeral
Director

5. Social Security Number

217-03-4948

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

86

Yrs.

If Under 1 Year

Months

If Under 24 Hrs.

Hours

Min.

8. Date of Birth
(Month, Day, Year)

Nov 25, 1917

9. Birthplace (State or Foreign
Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Baltimore

10c. City, Town or Location

Timonium

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

2203 Stryker Court

10f. Zip Code

21093

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced12. Was Decedent Ever in U.S.
Armed Forces?1 ☒ Yes 2 ☐ No
If Yes, Give
Year or Dates: 1942-4513. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.Specify:
White15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

08

College (1-4or 5+)

n/a

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Owner/Manager

16b. Kind of Business/Industry

Commercial Real Estate

17. Father's Name (First, Middle, Last)

James Leroy Elliott

18. Mother's Name (First, Middle, Maiden Surname)

Elizabeth Almony

19a. Informant's Name/Relationship (Type, Print)

Keith K. Price/Son-in-Law

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

12315 Michaelsford Road, Cockeysville, MD 21030

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Dulaney Valley Mem. Grdns.

Date

2/9/04

20c. Location - City or Town, State

Timonium, Maryland

21. Signature of Funeral Service Licensee

Bryan W. Clary

22. Name and Address of Facility

Lemmon Funeral Home of Dulaney Valley Inc.
10 W. Padonia Road, Timonium, MD 2109323a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)Sequentially list conditions,
if any, leading to immediate
Cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

a. Cardiac arrhythmia

b. Aspiration pneumonia

c. Respiratory failure

d.

Approximate
Interval Between
Onset and Death

IF FEMALE:

23b. Was decedent pregnant
in the past 12 months?
1 ☐ Yes 2 ☐ No
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy
4 ☐ Pregnant at time of death 5 ☐ Other (specify)
9 ☐ Unknown23d. Date of delivery
Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an
autopsy
performed?
1 ☐ Yes 2 ☒ No24b. Were autopsy findings available
prior to completion of cause of
death?
1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?
1 ☐ Yes 2 ☒ No26. Place of Death (Check only one)
Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending
investigation
2 ☐ Accident 6 ☐ Could not be
determined
3 ☐ Suicide 4 ☐ Homicide28a. Date of Injury
(Month, Day Year)28b. Time of
Injury

M

28c. Injury at
Work?
1 ☐ Yes 2 ☐ No28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
and manner stated.

29b. Signature and title of certifier

Susan Meltzer, M.D.

29c. License number

PA 2410

29d. Date signed (Month, Day, Year)

February 9, 2004

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Susan Meltzer, M.D. 12221-3 Tullamore Road Timonium, MD 21093

31. Date filed (Month, Day, Year)

FEB 10 2004

32. Registrar's Signature

B. Apple

State
Registrar

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show
any injury or other traumatic event, the Medical Examiner must be notified at
once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2004 03679

1- For
State
Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Venus A. Friers				2. Date of Death Month FEBRUARY Day 6 Year 2004		3. Time of Death 10:30 PM	
	4a. Facility Name (If not institution, give street and number) St. Agnes Healthcare				4b. City, Town, or Location of Death Baltimore		4c. County of Death	
Funeral Director	5. Social Security Number 212-07-0266		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 94 Yrs.		8. Date of Birth (Month, Day, Year) June 20, 1909		9. Birthplace (State or Foreign Country) Virginia
	Usual Residence of Decedent							
10a. State Maryland		10b. County Baltimore		10c. City, Town or Location Catonsville		10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
10e. Street and Number 1406 Ingleside Avenue				10f. Zip Code 21228		10g. Citizen of What Country? U.S.A.		
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) Unknown College (1-4 or 5+) Housewife				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Housewife		16b. Kind of Business/Industry Own Home		
17. Father's Name (First, Middle, Last) Unknown Wenger				18. Mother's Name (First, Middle, Maiden Surname) Unknown				
19a. Informant's Name/Relationship (Type, Print) Ronald Friers (Son)				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1406 Ingleside Avenue Catonsville, MD 21228				
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Lorraine Park Cemetery 2-10-2004 Woodlawn, Maryland		20c. Location - City or Town, State		
21. Signature of Funeral Service Licensee <i>[Signature]</i>				22. Name and Address of Facility Witzke Funeral Home of Catonsville, Inc. 1630 Edmondson Avenue Catonsville, Maryland 21228				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. PNEUMONIA								
23b. Immediate Cause (Final disease or condition resulting in death) HYPER TENSION								
23c. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):								
23d. Date of delivery Month February Day 6 Year 2004								
23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown								
23f. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No								
23g. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No								
23h. Describe how injury occurred								
23i. Location (Street and Number or Rural Route Number, City or Town, State)								
23j. Date of Injury (Month, Day Year)								
23k. Time of Injury M								
23l. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No								
23m. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)								
23n. Location (Street and Number or Rural Route Number, City or Town, State)								
23o. Certifier 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.								
23p. Signature and title of certifier Teodora Niculescu, MD								
23q. License number P17605								
23r. Date signed (Month, Day, Year) FEBRUARY 6, 2004								
23s. Name and address of person who completed cause of death (Item 23a) (Type, Print) TEODORA NICULESCU, MD, STAGNES HEALTHCARE, BALTIMORE, MD								
23t. Date filed (Month, Day, Year) FEB 10 2004								
23u. Registrar's Signature <i>[Signature]</i>								

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

State
Registrar

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2004 03680

1- For
State
RegistrarPhysician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

SUZANNE

FOREMAN

2. Date of Death

Month

Day

Year

FEB

6

2004

3. Time of Death

10

40

M

Funeral
Director

4a. Facility Name (If not institution, give street and number)

Sina Hospital

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

N/A

5. Social Security Number

214-40-9516

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

62

Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

Month

Day

Year

JAN

10

1942

9. Birthplace (State or Foreign Country)

MD

Usual Residence of Decedent

10a. State

MD

10b. County

N/A

10c. City, Town or Location

BALTIMORE

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

2500 WEST BELVEDERE AVE.

10f. Zip Code

21215

10g. Citizen of What Country?

U.S.A

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4or 5+)

4

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

REALTOR

16b. Kind of Business/Industry

REAL ESTATE

17. Father's Name (First, Middle, Last)

BENJAMIN

COHEN

18. Mother's Name (First, Middle, Maiden Surname)

MINYON

KRAMER

19a. Informant's Name/Relationship (Type, Print)

BRYAN FOREMAN/SON

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1802 ROAN COURT ELDERSBURG, MD. 21784

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

HEBREW YOUNG MENS

Date

2/8/2004

20c. Location - City or Town, State

WOODLAWN, MD.

21. Signature of Funeral Service Licensee

Edward C. Russell

22. Name and Address of Facility

SOL LEVINSON & BROS. INC.
8900 REISTERSTOWN - PIKESVILLE, MD 21208

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. MUCINOUS ADENOCARCINOMA

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☐ No3 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death3 ☐ Ectopic pregnancy4 ☐ Pregnant at time of death5 ☐ Other (specify)

23d. Date of delivery

Month

Day

Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

DISSEMINATED INTRAVASCULAR COAGULATION

Chronic Artery disease

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☒ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

RES - 060

29c. License number

RES - 060

29d. Date signed (Month, Day, Year)

FEBRUARY 6, 2004

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

J.A. Yelte, Jr., 2401 WEST BELVEDERE AVE., BALTIMORE MD 21215

31. Date filed (Month, Day, Year)

FEB 10 2004

32. Registrar's Signature

Susan K. Foreman

ORIGINAL

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

State
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2004 03681

1- For
State
Registrar

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Samuel Green		2. Date of Death Month Day Year February 02 2004		3. Time of Death 8:43AM
	4a. Facility Name (If not institution, give street and number) MARYLAND GENERAL Hospital		4b. City, Town, or Location of Death Baltimore City		4c. County of Death N/A
Funeral Director	5. Social Security Number 048-18-5922	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 79 Yrs.	8. Date of Birth (Month, Day, Year) Aug. 21, 1924	9. Birthplace (State or Foreign Country) Georgia
	Usual Residence of Decedent				
To Be Completed by Funeral Director	10a. State Maryland	10b. County N/A	10c. City, Town or Location Baltimore		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
	10e. Street and Number 2346 N. Eutan Place		10f. Zip Code 21217		10g. Citizen of What Country? USA
	11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:
	14. Race - American Indian, Black, White, etc. Specify: Black		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 4		
To Be Completed by Physician/Medical Examiner	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use, retired) Educator		16b. Kind of Business/Industry Morgan State University		
	17. Father's Name (First, Middle, Last) Joseph Green		18. Mother's Name (First, Middle, Maiden Surname) Edna Myers		
	19a. Informant's Name/Relationship (Type, Print) (Friend) Mrs. Marvis Lewis		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9318 Afternoon Lane Columbia Md. 21045		
	20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Green Mount Cemetery		20c. Location - City or Town, State Balto. Md.
21. Signature of Funeral Service Licensee Joseph L. Russ		22. Name and Address of Facility Joseph L. Russ Funeral Home 2222 W. North Ave. Balto. Md. 21216			
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. CARDIAC ARRHYTHMIA Due to (or as a consequence of): b. ISCHEMIC CARDIOMYOPATHY Due to (or as a consequence of): c. HYPERTENSION Due to (or as a consequence of): d. PERIPHERAL VASCULAR DISEASE				
	23b. IF FEMALE: Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown				
	23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <input type="checkbox"/> Unknown				
	23d. Date of delivery Month Day Year				
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.					
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No					
26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> VER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)			28b. Time of Injury M
28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred			
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.					
29b. Signature and title of certifier Sonia Yousof M.D.		29c. License number MD 84478		29d. Date signed (Month, Day, Year) February 2, 2004	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Sonia Yousof M.D. C/O MARYLAND GENERAL Hospital					
31. Date filed (Month, Day, Year) FEB 10 2004		32. Registrar's Signature [Signature]			

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "Natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2004 03682

1- For
State
RegistrarPhysician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Theodore F. Gress

2. Date of Death
Month Day Year
February 9, 20043. Time of Death
4:58 P.M.Funeral
Director

4a. Facility Name (If not institution, give street and number)

Franklin Square Hospital Center

4b. City, Town, or Location of Death

Rosedale

4c. County of Death

Baltimore

5. Social Security Number

213-05-6581

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

90 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth
(Month, Day, Year)

Aug. 5, 1913

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

MD

10b. County

Baltimore

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

8107 Candle Lane

10f. Zip Code

21221

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced12. Was Decedent Ever in U.S.
Armed Forces?1 ☐ Yes 2 ☒ No
If Yes, Give
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify White

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

8th

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Master Mechanic

16b. Kind of Business/Industry

Exxon

17. Father's Name (First, Middle, Last)

John Gress

18. Mother's Name (First, Middle, Maiden Surname)

Katie Hoffman

19a. Informant's Name/Relationship (Type, Print)

Ruth M. Gress /wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

8107 Candle Lane Baltimore MD

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

GardensofFaith

Date

2/12/04

20c. Location - City or Town, State

Rossville MD

21. Signature of Funeral Service Licensee

K. Terry Connelly

22. Name and Address of Facility

ConnellyFuneralHomeofEssex
300 Mace Ave. Baltimore MD 2122123a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

a. Aspiration Pneumonia

Due to (or as a consequence of):

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

b. Lung Cancer

Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate
Interval Between
Onset and Death

IF FEMALE:

23b. Was decedent pregnant
in the past 12 months?1 ☐ Yes 2 ☐ No
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy
4 ☐ Pregnant at time of death 5 ☐ Other (specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Asbestosis
CAP

23e. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown24a. Was an
autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings available
prior to completion of cause of
death?1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending
investigation
2 ☐ Accident 6 ☐ Could not be
determined
3 ☐ Suicide 4 ☐ Homicide28a. Date of Injury
(Month, Day Year)28b. Time of
Injury28c. Injury at
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
and manner stated.

29b. Signature and title of certifier

James McGovern

29c. License number

D57255

29d. Date signed (Month, Day, Year)

2/9/2004

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Dr. James McGovern, 9000 Franklin Square Drive, Baltimore, MD 21237

31. Date filed (Month, Day, Year)

32. Registrar's Signature

FEB 10 2004

State
Registrar

ORIGINAL

Gress, Theodore
Baltimore, Maryland 21215-0036
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or item 23a or 28a-f show
any injury or other traumatic event, the Medical Examiner must be notified at
once.Division of Vital Records, P.O. Box 68760,
To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit
certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2004 03683

1- For State Registrar AMEND ITEM #1 PER PHY G828 2/10/04 JA Certificate of Death

Reg. No.

Physician / Medical Examiner	1. Decedent's Name (First, Middle, Last) <u>WILLIAM H. GEORGE, Jr.</u>				2. Date of Death Month <u>02</u> Day <u>04</u> Year <u>2004</u>		3. Time of Death <u>10¹⁰ AM</u>	
	4a. Facility Name (If not institution, give street and number) <u>Bon Secours Hospital</u>				4b. City, Town, or Location of Death <u>Baltimore</u>		4c. County of Death <u>N/A</u>	
Funeral Director	5. Social Security Number <u>918-60-2510</u>		6. Sex <u>1</u> M <u>2</u> F		7. Age (In yrs. last birthday) <u>51</u> Yrs.		8. Date of Birth (Month, Day, Year) <u>June 18, 1952</u>	
	9. Birthplace (State or Foreign Country) <u>Maryland</u>		10a. State <u>MD</u>		10b. County <u>Baltimore</u>		10c. City, Town or Location <u>Pikesville</u>	
To Be Completed by Funeral Director	10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		10e. Street and Number <u>4706 Bonnie Brae Rd.</u>		10f. Zip Code <u>21208</u>		10g. Citizen of What Country? <u>USA</u>	
	11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <u>Black</u>	
To Be Completed by Physician/Medical Examiner	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <u>High</u> College (1-4or 5+) <u>College</u>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <u>Mechanic</u>		16b. Kind of Business/Industry <u>City</u>			
	17. Father's Name (First, Middle, Last) <u>William George Sr.</u>				18. Mother's Name (First, Middle, Maiden Surname) <u>Ernestine Ellison</u>			
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) <u>William George Sr. - Father</u>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>4706 Bonnie Brae Rd. Pikesville, MD 21208</u>			
	20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <u>Metro Crematory</u>		20c. Location - City or Town, State <u>8-12-04 Catonsville, MD</u>		20d. Date	
To Be Completed by Physician/Medical Examiner	21. Signature of Funeral Service Location <u>[Signature]</u>		22. Name and Address of Facility <u>Gary P. March F/H 270 Fred Hilton Pass Balto, MD</u>		22. Date <u>2/2/04</u>			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) <u>Respiratory Failure</u> Due to (or as a consequence of): <u>Pneumococcal Pneumonia</u>		23b. If female, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <input type="checkbox"/> Unknown		23c. Date of delivery Month <u>2</u> Day <u>4</u> Year <u>2004</u>			
To Be Completed by Physician/Medical Examiner	23d. Part II. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <u>Acute Renal Failure</u> <u>Human Immunodeficiency Virus Infection</u>		23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		23f. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
	23g. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		23h. Date of death Month <u>2</u> Day <u>4</u> Year <u>2004</u>		23i. Date of death Month <u>2</u> Day <u>4</u> Year <u>2004</u>			
To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		26. Date of Injury (Month, Day, Year) <u>2/4/04</u>			
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year) <u>2/4/04</u>		28b. Time of Injury <u>M</u>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
To Be Completed by Physician/Medical Examiner	28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier <u>[Signature]</u>		29c. License number <u>D27163</u>		29d. Date signed (Month, Day, Year) <u>2/4/2004</u>	
To Be Completed by Physician/Medical Examiner	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <u>Harold Reynolds, Bon Secours Hospital of Baltimore</u>		31. Date filed (Month, Day, Year) <u>FEB 10 2004</u>		32. Registrar's Signature <u>[Signature]</u>			
	33. State Registrar		34. State Registrar		35. State Registrar			

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23e-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial transit

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar **Unpend Item #23a, 27, 28a-f, Per ME, G828-2/13/04**

Reg. No.

2004 03684

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) DENISE ANN GASKINS			2. Date of Death Month Day Year February 05, 2004		3. Time of Death M 19:16				
	4a. Facility Name (If not institution, give street and number) Maryland General Hospital			4b. City, Town, or Location of Death Baltimore		4c. County of Death				
Funeral Director	5. Social Security Number 218-76-0620		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs./last birthday) 44 Yrs.	8. Date of Birth (Month, Day, Year) MARCH 7, 1959		9. Birthplace (State or Foreign Country) MARYLAND			
	Usual Residence of Decedent									
10a. State MD		10b. County		10c. City, Town or Location BALTIMORE		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No				
10e. Street and Number 1901 W. NORTH AVE.			10f. Zip Code 21217		10g. Citizen of What Country? U.S.A.					
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: BLACK				
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12th College (1-4 or 5+)			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) DOMESTIC		16b. Kind of Business/Industry PRIVATE					
17. Father's Name (First, Middle, Last) THOMAS R. TAYLOR				18. Mother's Name (First, Middle, Maiden Surname) RUSALICE BAILEY						
19a. Informant's Name/Relationship (Type, Print) FREE MAN TANNER, JR./SON				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1515 N. CAREY ST. BALTO, MD 21217						
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) GREENMOUNT CREMATORY		20c. Location - City or Town, State 2-11-04 BALTIMORE MARYLAND						
21. Signature of Funeral Service Licensee [Signature]		22. Name and Address of Facility CREMATION SERVICES P.A. 5151 BALTIMORE NATIONAL PIKE BALTO, MD 21229								
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Cocaine Intoxication Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last							Approximate Interval Between Onset and Death			
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown							23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <input type="checkbox"/> Unknown		23d. Date of delivery Month Day Year	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown			
24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No							24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No			
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA		Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		26. Place of Death (Check only one)				
27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input checked="" type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year) 2/5/04		28b. Time of Injury 6:36 PM		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				
		28d. Describe how injury occurred unknown		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) found: private dwelling		28f. Location (Street and Number or Rural Route Number, City or Town, State) 1846 West North Avenue, Apt. 1, Baltimore City, MD				
29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.							29b. Signature and title of certifier [Signature] O.C.M.E.		29c. License number	
29d. Date signed (Month, Day, Year) February 06, 2004										
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) S.R. HOGAN 111 Penn Street, Baltimore, Maryland 21201										
31. Date filed (Month, Day, Year) FEB 10 2004		32. Registrar's Signature [Signature]								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

1- For
State
Registrar

2004 03685

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Wesley Edward Gentry				2. Date of Death Month 2 Day 6 Year 2004		3. Time of Death 11:40a M	
	4a. Facility Name (If not institution, give street and number) Multi Medical Center				4b. City, Town, or Location of Death Towson		4c. County of Death Baltimore	
Funeral Director	5. Social Security Number 238-20-3102		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 86 Yrs.		8. Date of Birth (Month, Day, Year) 5-12-17	
	9. Birthplace (State or Foreign Country) N.C.		10a. State Md.		10b. County NA		10c. City, Town or Location Baltimore	
10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		10e. Street and Number 501 E. Preston St. Apt. 116		10f. Zip Code 21202		10g. Citizen of What Country? USA		
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: Black		
15. Decedent's Education (Specify only highest grade completed) 7th grade		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Construction		16b. Kind of Business/Industry Varies				
17. Father's Name (First, Middle, Last) Pete Gentry		18. Mother's Name (First, Middle, Maiden Surname) Ida Boles		19a. Informant's Name/Relationship (Type, Print) Frances Wellborn Sister		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 501 E. Preston St. Apt. 116, Baltimore, Md. 21202		
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Md. Vet. Cem.		20c. Location - City or Town, State 2-11-04 Crownsville, Md.				
21. Signature of Funeral Service Licensee 		22. Name and Address of Facility Baltimore, Md. 21202 March F.H. East 1101 E. North Ave.						
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. ARTERIOSCLEROTIC DISEASE Due to (or as a consequence of): b. CARDIOVASCULAR DISEASE Due to (or as a consequence of): c. Due to (or as a consequence of): d.		23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fatal death <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Other (specify) <input type="checkbox"/> Unknown		23d. Date of delivery Month Day Year		
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown		24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		
28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		
28f. Location (Street and Number or Rural Route Number, City or Town, State)		29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier 		29c. License number DZ1680		
29d. Date signed (Month, Day, Year) 2/9/04		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) HOWARD B. CHEN, M.D.		31. Date filed (Month, Day, Year) FEB 10 2004		32. Registrar's Signature 		
32. Registrar's Signature		33. Date filed (Month, Day, Year)		34. Registrar's Signature		35. Date filed (Month, Day, Year)		

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Johnnie Griffin

04-0984

AKG

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2004 03686

1- For State Registrar Unpend Item 23a-27, Per ME, C828, 3/4/04 Certificate of Death

Reg. No.

3138

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 23b-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) JOHNNIE ELLIOTT GRIFFIN		2. Date of Death Month Day Year February 2, 2004		3. Time of Death 6:22 P M																										
	4a. Facility Name (If not institution, give street and number) Sinai Hospital		4b. City, Town, or Location of Death Baltimore		4c. County of Death N/A																										
Funeral Director	5. Social Security Number 213 52 2835	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 54 Yrs.	8. Date of Birth (Month, Day, Year) Mar. 29, 1949	9. Birthplace (State or Foreign Country) Maryland																										
	10a. State Maryland		10b. County N/A	10c. City, Town or Location Baltimore																											
10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		10e. Street and Number 5506 Magnolia Ave		10f. Zip Code 21215	10g. Citizen of What Country? USA																										
11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:																											
14. Race - American Indian, Black, White, etc. Specify: Black		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12th grade College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) LONG SHOREMAN																											
16b. Kind of Business/Industry Private Industry		17. Father's Name (First, Middle, Last) Frank Griffin		18. Mother's Name (First, Middle, Maiden Surname) Elizabeth Patterson																											
19a. Informant's Name/Relationship (Type, Print) Jimmy Griffin / Brother		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9525 MEADOWS FARM Dr. Owings Mills, Md 21117																													
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) MT Zion Cemetery		20c. Location - City or Town, State Baltimore Maryland																											
21. Signature of Funeral Service Licensee [Signature]		22. Name and Address of Facility CHATHAM - HARRIS Funeral Home 5240 REISTERSTOWN RD BALTIMORE, MD 21215																													
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.																															
<table border="1"> <tr> <td rowspan="4"> Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last </td> <td colspan="5"> Hypertensive Atherosclerotic Cardiovascular Disease </td> </tr> <tr> <td colspan="5">a. Due to (or as a consequence of):</td> </tr> <tr> <td colspan="5">b. Due to (or as a consequence of):</td> </tr> <tr> <td colspan="5">c. Due to (or as a consequence of):</td> </tr> <tr> <td colspan="5">d.</td> </tr> </table>						Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Hypertensive Atherosclerotic Cardiovascular Disease					a. Due to (or as a consequence of):					b. Due to (or as a consequence of):					c. Due to (or as a consequence of):					d.				
Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Hypertensive Atherosclerotic Cardiovascular Disease																														
	a. Due to (or as a consequence of):																														
	b. Due to (or as a consequence of):																														
	c. Due to (or as a consequence of):																														
d.																															
<table border="1"> <tr> <td> IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown </td> <td colspan="3"> 23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (Specify) </td> <td colspan="2"> 23d. Date of delivery Month Day Year </td> </tr> </table>						IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown	23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (Specify)			23d. Date of delivery Month Day Year																					
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown	23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (Specify)			23d. Date of delivery Month Day Year																											
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.																															
23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown																															
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No																															
24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No																															
25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No																															
26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)																															
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M																											
28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)																											
28f. Location (Street and Number or Rural Route Number, City or Town, State)		29a. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.																													
29b. Signature and title of certifier Theodore M. King		29c. License number O.C.M.E.		29d. Date signed (Month, Day, Year) February 5, 2004																											
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) THEODORE M. KING 111 Penn Street, Baltimore, Maryland 21201																															
31. Date filed (Month, Day, Year) FEB 10 2004		32. Registrar's Signature [Signature]																													

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2004 03687

1- For
State
RegistrarPhysician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Andrew Robert Goss

2. Date of Death
Month Day Year
February 6, 20043. Time of Death
8:30 A MFuneral
Director

4a. Facility Name (If not institution, give street and number)

Upper Chesapeake Medical Center

4b. City, Town, or Location of Death

Bel Air

4c. County of Death

Harford

5. Social Security Number

215-07-8874

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

89 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth (Month, Day, Year)

Jan. 3, 1915

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State
Maryland

10b. County

Harford

10c. City, Town or Location

Edgewood

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

1205 Hanson Road

10f. Zip Code

21040

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)
12th Grade

College (1-4or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DD NDT use retired)

Contractor

16b. Kind of Business/Industry

Construction

17. Father's Name (First, Middle, Last)

Andrew Goss

18. Mother's Name (First, Middle, Maiden Surname)

Regina Mueller

19a. Informant's Name/Relationship (Type, Print)

Mrs. Mary L. Bockstie (sister)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

79 Basil Ave., Chesapeake City, MD 21915

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

St. Joseph Ch. Cem.

Date

2/10/2004

20c. Location - City or Town, State

Fullerton, Maryland

21. Signature of Funeral Service Licensee

[Signature]

22. Name and Address of Facility

Schimunek Funeral Homes
9705 Belair Rd., Baltimore, MD 21236

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Acute Respiratory Failure

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

days

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Septicemia

Due to (or as a consequence of):

days

c. Urrosepsis, Urinary tract infection

Due to (or as a consequence of):

days

d. Diabetes Mellitus

Due to (or as a consequence of):

years

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☐ No
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 5 ☐ Other (specify)
9 ☐ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ NoHospital: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

[Signature]

29c. License number

D-18779

29d. Date signed (Month, Day, Year)

February 6, 2004

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ALBERT S. SUN, MD, 1716 Harford Road Suite 105 Fallston MD

31. Date filed (Month, Day, Year)

FEB 10 2004

32. Registrar's Signature

[Signature]

21047

State
Registrar

ORIGINAL

Baltimore, Maryland 21215-0036
perm. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2004 03688

1- For State Registrar

Physician / Medical Examiner	1. Decedent's Name (First, Middle, Last) <u>Cora</u>			2. Date of Death Month <u>February</u> Day <u>7</u> Year <u>2004</u>			3. Time of Death <u>5:55AM</u>				
	4a. Facility Name (If not institution, give street and number) <u>The Johns Hopkins Hospital</u>			4b. City, Town, or Location of Death <u>Baltimore City</u>			4c. County of Death				
Funeral Director	5. Social Security Number <u>144 30 7545</u>		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <u>63</u> Yrs.		8. Date of Birth (Month, Day, Year) <u>AUG. 22, 1940</u>		9. Birthplace (State or Foreign) <u>NORTH CAROLINA</u>		
	10a. State <u>MD.</u>			10b. County <u>N/A</u>		10c. City, Town or Location <u>BALTIMORE</u>			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
To Be Completed by Funeral Director	10e. Street and Number <u>1431 E. PRESTON STREET</u>			10f. Zip Code <u>21213</u>			10g. Citizen of What Country? <u>U.S.A.</u>				
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <u>BLACK</u>			
	15. Decedent's Education (Specify only highest grade completed) <u>9th</u>			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <u>ICCU NURSE</u>			16b. Kind of Business/Industry <u>NURSING</u>				
	17. Father's Name (First, Middle, Last) <u>GEORGE HENRY JOHNSON</u>			18. Mother's Name (First, Middle, Maiden Surname) <u>CORA WARREM</u>							
	19a. Informant's Name/Relationship (Type, Print) <u>KAY STALLINGS (DAUGHTER)</u>			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>1431 E. PRESTON ST. BALTO, MD. 21213</u>							
	20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) <u>MT. ZION CEMETERY Feb. 13, 2004 BALTO, MD.</u>			20c. Location - City or Town, State				
	21. Signature of Funeral Service Licensee <u>Bernadine Scruggs</u>			22. Name and Address of Facility <u>CALVIN B. SCRUGGS FUNERAL HOME</u> <u>1412 E. PRESTON ST. BALTO, MD. 21213</u>							
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. <u>Anoxic brain damage</u> Due to (or as a consequence of): b. <u>Asystolic cardiac arrest</u> Due to (or as a consequence of): c. <u>Seizure</u> Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last						Approximate Interval Between Onset and Death <u>5 days</u> <u>5 days</u> <u>5 days</u>				
	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 9 <input type="checkbox"/> Unknown			23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) 9 <input type="checkbox"/> Unknown			23d. Date of delivery Month Day Year				
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>Alcohol abuse</u>			23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown							
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA			26. Place of Death (Check only one) Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined			28a. Date of Injury (Month, Day Year)		28b. Time of Injury <u>M</u>		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		28d. Describe how injury occurred		
28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)								
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.			29b. Signature and title of certifier <u>[Signature]</u> MD			29c. License number <u>RES-000</u>			29d. Date signed (Month, Day, Year) <u>February 8, 2004</u>		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <u>John Dooley 600 North Wolfe Street Baltimore, Maryland 21287</u>											
31. Date filed (Month, Day, Year) <u>FEB 10 2004</u>			32. Registrar's Signature <u>[Signature]</u>								

Baltimore, Maryland 21215-0036
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician / Medical Examiner
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Division of Vital Records, P.O. Box 68760,

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2004 03689

Certificate of Death

Reg. No.

1- For
State
Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Dolores H. Hutson			2. Date of Death Month Feb. Day 6 Year 2004		3. Time of Death 9:45pM	
	4a. Facility Name (If not institution, give street and number) 138 N. Kenwood Ave.			4b. City, Town, or Location of Death Baltimore		4c. County of Death n/a	
Funeral Director	5. Social Security Number 115-26-6377		6. Sex 1 M 2 F		7. Age (In yrs. last birthday) 69 Yrs.		8. Date of Birth (Month, Day, Year) Dec. 24, 1934
	9. Birthplace (State or Foreign Country) Maryland						
Usual Residence of Decedent							
10a. State MD		10b. County Baltimore		10c. City, Town or Location Baltimore		10d. Inside City Limits 1 Yes 2 No	
10e. Street and Number 138 N. Kenwood Ave.				10f. Zip Code 21224		10g. Citizen of What Country? USA	
11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Yes 2 No Specify:		14. Race - American Indian, Black, White, etc. Specify: White	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12th				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker		16b. Kind of Business/Industry own home	
17. Father's Name (First, Middle, Last) John Howard Hutchinson				18. Mother's Name (First, Middle, Maiden Surname) Lillian D. Thompson			
19a. Informant's Name/Relationship (Type, Print) William Hutson /son				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 28 Woodsman Court Baltimore Maryland			
20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Holy Redeemer		Date 2/10/04		20c. Location - City or Town, State Baltimore MD	
21. Signature of Funeral Service Licensee R. Terry Connelly		22. Name and Address of Facility Connelly Funeral Home of Essex 300 Mace Ave. Baltimore MD 21221					
23a. Part I. Enter the disease, or complications that caused the death, or not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. METASTATIC OVARIAN CANCER							
Approximate Interval Between Onset and Death 42 MONTHS							
Immediate Cause (Final disease or condition resulting in death) a. Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of):							
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last							
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown		23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 4 Pregnant at time of death 9 Unknown		3 Ectopic pregnancy 5 Other (specify)		23d. Date of delivery Month Day Year	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown	
24a. Was an autopsy performed? 1 Yes 2 No						24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No	
25. Was case referred to medical examiner? 1 Yes 2 No		26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify)					
27. Manner of Death 1 Natural 5 Pending investigation 2 Accident 6 Could not be determined 3 Suicide 4 Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M 1 Yes 2 No		28c. Injury at Work? 1 Yes 2 No	
28d. Describe how injury occurred				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			
28f. Location (Street and Number or Rural Route Number, City or Town, State)							
29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier A. Chowell, MD		29c. License number 039774		29d. Date signed (Month, Day, Year) 2/9/04	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) JOHNS HOPKINS CANCER CENTER							
31. Date filed (Month, Day, Year) FEB 10 2004		32. Registrar's Signature [Signature]					

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial transit

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar AMEND ITEM #5,8.19b20a-c PER FH G828 2/20/04 Certificate of Death

Reg. No.

2004 03690

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Delores Howard		2. Date of Death Month January Day 30 Year 2004		3. Time of Death 16:25 PM
	4a. Facility Name (If not institution, give street and number) University Specialty Hospital		4b. City, Town, or Location of Death Baltimore		4c. County of Death N/A
Funeral Director	5. Social Security Number 214-56-5538	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 55 Yrs.	If Under 1 Year Months	If Under 24 Hrs. Hours Min.
	8. Date of Birth (Month, Day, Year) SEP 19, 1948		9. Birthplace (State or Foreign Country) Maryland		
To Be Completed by Funeral Director	10a. State Maryland		10b. County N/A		10c. City, Town or Location Baltimore
	10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		10e. Street and Number 3507 Copley Rd.		10f. Zip Code 21215
	10g. Citizen of What Country? USA		11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:
	13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: Black		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 0
	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Receptionist		16b. Kind of Business/Industry Private		
To Be Completed by Physician/Medical Examiner	17. Father's Name (First, Middle, Last) Russell Carter		18. Mother's Name (First, Middle, Maiden Surname) Beatrice Scarborough		
	19a. Informant's Name/Relationship (Type, Print) (cousin) Mr. Charles Woodland		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3507 COPLEY RD BALTO, MD 21215		
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) LORRAINE PARK CEM		20c. Location - City or Town, State Balto. Md.
	21. Signature of Funeral Service Licensee Joseph L. Russ		22. Name and Address of Facility Joseph L. Russ Funeral Home 2222 W. North Ave. Balto. Md. 21216		
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Restrictive lung disease Due to (or as a consequence of): b. cor pulmonale Due to (or as a consequence of): c. Anoxic encephalopathy Due to (or as a consequence of): d.		Approximate Interval Between Onset and Death yes yes 6 weeks		
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <input type="checkbox"/> Unknown		23d. Date of delivery Month Day Year	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.					23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M	
28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred			
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.					
29b. Signature and title of certifier CP Nehtam		29c. License number D 34974		29d. Date signed (Month, Day, Year) Jan 30th 2004	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CHARU MEHTA, MD 601 South Charles Street, Baltimore, MD 21230					
31. Date filed (Month, Day, Year) FEB 10 2004		32. Registrar's Signature Sparks			

Howard Delores
Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,
Baltimore, Maryland 21215-0036

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2004 03691

1- For
State
Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) ROSA LEE HAMLET			2. Date of Death Month Day Year February 6, 2004		3. Time of Death 11:00 AM		
	4a. Facility Name (If not institution, give street and number) Gilchrist Nursing Home			4b. City, Town, or Location of Death Baltimore		4c. County of Death n/A		
Funeral Director	5. Social Security Number 216-22-3957		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (in yrs. last birthday) 83 Yrs.		8. Date of Birth (Month, Day, Year) 06-19-1920	
	9. Birthplace (State or Foreign Country) S. Carolina							
To Be Completed by Funeral Director	10a. State Md		10b. County Baltimore		10c. City, Town or Location Catonsville		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	10e. Street and Number 36 Clinton Hill Court				10f. Zip Code 21228		10g. Citizen of What Country? U.S.A.	
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: Black	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 6th College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Housekeeper		16b. Kind of Business/Industry Domestic			
	17. Father's Name (First, Middle, Last) Nathaniel McDonald				18. Mother's Name (First, Middle, Maiden Surname) Lessie McAllister			
	19a. Informant's Name/Relationship (Type, Print) Cynthia Hamlet				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 36 Clinton Hill Court, Baltimore, MD 21228			
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Woodlawn Cemetery		20c. Location - City or Town, State Baltimore, MD		20d. Date 2/11/04	
	21. Signature of Funeral Service Licensee Willie E. Howell				22. Name and Address of Facility Howell Funeral Home 4600 Liberty Heights Avenue			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) pancreatic cancer							Approximate Interval Between Onset and Death years
	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last a. Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d.							
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <input type="checkbox"/> Unknown		23d. Date of delivery Month Day Year				
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No						
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) Hospice						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
28d. Describe how injury occurred				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				
28f. Location (Street and Number or Rural Route Number, City or Town, State)								
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
29b. Signature and title of certifier W.A. Riley, MD				29c. License number D25205		29d. Date signed (Month, Day, Year) February 6, 2004		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) W.A. Riley, MD, 6701 N. Charles St. Balt. MD 21208								
31. Date filed (Month, Day, Year) FEB 10 2004		32. Registrar's Signature [Signature]						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2004 03692

1- For
State
Registrar

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial transit

Physician
/Medical
ExaminerFuneral
Director

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

1. Decedent's Name (First, Middle, Last) Dian Harris		2. Date of Death Month February Day 5 Year 2004		3. Time of Death 03:50 M	
4a. Facility Name (If not institution, give street and number) Johns Hopkins Bayview		4b. City, Town, or Location of Death Baltimore		4c. County of Death N/A	
5. Social Security Number 217-34-7604	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 66 Yrs.	8. Date of Birth (Month, Day, Year) OCT. 25, 1937	9. Birthplace (State or Foreign Country) Maryland	
Usual Residence of Decedent					
10a. State Maryland	10b. County N/A	10c. City, Town or Location Baltimore		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
10e. Street and Number 4304 Nicholas Avenue		10f. Zip Code 21206		10g. Citizen of What Country? USA	
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:	
14. Race - American Indian, Black, White, etc. Specify: White		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 10 College (1-4 or 5+)			
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker		16b. Kind of Business/Industry Own Home			
17. Father's Name (First, Middle, Last) John C. Kuhn			18. Mother's Name (First, Middle, Maiden Surname) Ruth Heim		
19a. Informant's Name/Relationship (Type, Print) Ruth Murphy/daughter			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6014 Pinehurst Road Baltimore, MD 21212		
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Metro Crematory, Inc.		20c. Location - City or Town, State Baltimore, MD	
21. Signature of Funeral Service Licensee Thomas Gregor		22. Name and Address of Facility Cremation Society of Maryland, Inc. 299 Frederick Road Baltimore, MD 21228			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.					
Immediate Cause (Final disease or condition resulting in death)					
a. Cardiac ischemia					
Due to (or as a consequence of):					
b. Anemia					
Due to (or as a consequence of):					
c. Acute Hemorrhage					
Due to (or as a consequence of):					
d.					
Approximate Interval Between Onset and Death 10 minutes 1 day 1 day					
IF FEMALE:					
23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <input type="checkbox"/> Unknown		23d. Date of delivery Month Day Year	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.					
23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown					
24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M	
28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred			
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.					
29b. Signature and title of certifier G. Bla		29c. License number RES-000		29d. Date signed (Month, Day, Year) 2/6/04	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Gerald Bloomfield 4940 Eastern Avenue Baltimore, MD 21234					
31. Date filed (Month, Day, Year) FFR 10 2004		32. Registrar's Signature [Signature]			

State
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2004 03693

1- For
State
RegistrarPhysician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Patricia Helen Haydock

2. Date of Death

Month Day Year
FEB 6, 2004

3. Time of Death

7:30a M

Funeral
Director

4a. Facility Name (If not institution, give street and number)

351 Broadview Lane

4b. City, Town, or Location of Death

Annapolis

4c. County of Death

Anne Arundel

5. Social Security Number

031-18-0550

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

78 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
AUG 13, 1925

9. Birthplace (State or Foreign Country)

Massachusetts

Usual Residence of Decedent

10a. State

Maryland

10b. County

Anne Arundel

10c. City, Town or Location

Annapolis

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

570 Bellerive Drive Apt. 237

10f. Zip Code

21401

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4or 5+)

4

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Nurse

16b. Kind of Business/Industry

Healthcare

17. Father's Name (First, Middle, Last)

Walter Yankowski

18. Mother's Name (First, Middle, Maiden Surname)

Petronella Laurenitis

19a. Informant's Name/Relationship (Type, Print)

Valerie Jean Leitzel/daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

351 Broadview Lane Annapolis, MD 21401

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Metro Crematory, Inc. 2/7/04

Date

20c. Location - City or Town, State

Baltimore, MD

21. Signature of Funeral Service Provider

Dawn F. McDonald

22. Name and Address of Facility

Cremation Society of Maryland, Inc.

299 Frederick Road Baltimore, MD 21228

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. *Metastatic sarcoma to lungs*

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

4 weeks

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☒ No
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 5 ☐ Other (Specify)
9 ☐ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy performed?
1 ☐ Yes 2 ☒ No24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☒ No25. Was case referred to medical examiner?
1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☒ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation
2 ☐ Accident 6 ☐ Could not be determined
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☒ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Kristy L. Weber, M.D.

29c. License number

D0060980

29d. Date signed (Month, Day, Year)

2/6/04

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Kristy L. Weber, M.D. 601 N. Caroline Street Rm #5251 Baltimore, MD 21287-0882

31. Date filed (Month, Day, Year)

FEB 10 2004

32. Registrar's Signature

[Signature]

State
Registrar

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial/transit

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2004 03694

1- For
State
RegistrarPhysician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

William R. Horan

2. Date of Death

Month Day Year
FEBRUARY 3 2004

3. Time of Death

7:44 PM

4a. Facility Name (If not institution, give street and number)

NORTHWEST HOSPITAL CENTER

4b. City, Town, or Location of Death

RANDALLSTOWN

4c. County of Death

BALTIMORE

Funeral
Director

5. Social Security Number

6. Sex
☒ M ☐ F

7. Age (In yrs. last birthday)

78

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
Sept. 8, 1925

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Baltimore

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

3530 Meadowside Avenue

10f. Zip Code

21207

10g. Citizen of What Country?

Unites States

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
☒ Yes 2 ☐ No
If Yes, Give Year or Dates: WWII13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: White

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4or 5+)

-

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Administrative

16b. Kind of Business/Industry

Social Security

17. Father's Name (First, Middle, Last)

William Burton Horan

18. Mother's Name (First, Middle, Maiden Surname)

Emilye Marie Miller

19a. Informant's Name/Relationship (Type, Print)

Shirley Horan

Sister

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

3530 Meadowside Road, Gwynn Oak, MD 21207

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Lake View Memorial Park

Date

February 7, 2004 Sykesville, MD

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

Joseph D. Kellner #00333

22. Name and Address of Facility

Loring Byers Funeral Directors, Inc.
8728 Liberty Rd., Randallstown, MD 21133-478423a. Part I. Enter the disease(s) or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)a. PNEUMONIA
Due to (or as a consequence of):Approximate
Interval Between
Onset and DeathSequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

IF FEMALE:

23b. Was decedent pregnant

in the past 12 months?
1 ☐ Yes 2 ☐ No
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 5 ☐ Other (specify)
9 ☐ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

PARKINSONISM

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an
autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings available
prior to completion of cause of
death?1 ☐ Yes 2 ☒ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending
2 ☐ Accident investigation
3 ☐ Suicide 6 ☐ Could not be
4 ☐ Homicide determined

28a. Date of Injury

(Month, Day Year)

28b. Time of
Injury28c. Injury at
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

ORLANDO B. CONAWAY MD

29c. License number

J19502

29d. Date signed (Month, Day, Year)

FEBRUARY 3, 2004

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ORLANDO B. CONAWAY MD

NORTHWEST HOSPITAL CENTER
RANDALLSTOWN, MARYLAND 21133

31. Date filed (Month, Day, Year)

FEB 10 2004

32. Registrar's Signature

[Signature]

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or item 23a or 28a-1 show
any injury or other traumatic event, the Medical Examiner must be notified at
once.Physician
/Medical
ExaminerTo the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2004 03695

1- For
State
RegistrarPhysician
/Medical
ExaminerFuneral
Director

1. Decedent's Name (First, Middle, Last)

Edwin Phillips Hathaway

2. Date of Death

February 6 2004

3. Time of Death

11:30 P^M

4a. Facility Name (If not institution, give street and number)

11008 Baronet Road

4b. City, Town, or Location of Death

Owings Mills

4c. County of Death

Baltimore

5. Social Security Number

216-14-8954

6. Sex

M 2 ☒ F

7. Age (In yrs. last birthday)

83

8. Date of Birth

June 14, 1920

9. Birthplace (State or Foreign Country)

Boston, Mass

Usual Residence of Decedent

10a. State

Md

10b. County

Baltimore

10c. City, Town or Location

Owings Mills

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

11008 Baronet Road

10f. Zip Code

21117

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☒ Yes 2 ☐ No
If Yes, Give Year or Dates: 1941-1945

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)
12

College (1-4or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Investment Banker

16b. Kind of Business/Industry

Financial

17. Father's Name (First, Middle, Last)

Harold Grant Hathaway

18. Mother's Name (First, Middle, Maiden Surname)

Louise Phillips

19a. Informant's Name/Relationship (Type, Print)

Barbara M. Hathaway Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

11008 Baronet Road, Owings Mills, Md 21117

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Carroll Cremations

Date

2/09/2004

20c. Location - City or Town, State

Hampstead, MD

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Eline Funeral Home 11824 Reisterstown Road
Reisterstown Md 21136

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

a. Due to (or as a consequence of):

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☒ No
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 5 ☐ Other (specify)
9 ☐ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation
2 ☐ Accident 6 ☐ Could not be determined
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number

D0025269

29d. Date signed (Month, Day, Year)

2/7/04

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

David Berliner 6569 N. Charles St Towson 21204

31. Date filed (Month, Day, Year)

FEB 10 2004

32. Registrar's Signature

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

State
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2004 03696

1- For
State
Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Kari L. Harrell		2. Date of Death Month February Day 4 Year 2004		3. Time of Death 5:00 A.M.
	4a. Facility Name (If not institution, give street and number) 4107 Doris Avenue		4b. City, Town, or Location of Death Baltimore		4c. County of Death N/A
Funeral Director	5. Social Security Number 216 68 4744	6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 47 Yrs.	8. Date of Birth (Month, Day, Year) Feb. 20, 1956	9. Birthplace (State or Foreign Country) Maryland
	Usual Residence of Decedent				
To Be Completed by Funeral Director	10a. State Maryland	10b. County N/A	10c. City, Town or Location Baltimore		10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No
	10e. Street and Number 4107 Doris Avenue		10f. Zip Code 21225		10g. Citizen of What Country? U.S.
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:
	14. Race - American Indian, Black, White, etc. Specify: White		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12th College (1-4or 5+) Data Entry		
	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Appraisal Company		16b. Kind of Business/Industry		
To Be Completed by Physician/Medical Examiner	17. Father's Name (First, Middle, Last) Charles Wesley Gardner		18. Mother's Name (First, Middle, Maiden Surname) Mildred Aline Walker		
	19a. Informant's Name/Relationship (Type, Print) Crystal Harrell / Daughter		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3823 Mount Pleasant Baltimore, Maryland 21224		
	20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Bayview Crematory		20c. Location - City or Town, State 2/5/2004 Baltimore, Maryland
	21. Signature of Funeral Service Licensee <i>[Signature]</i>		22. Name and Address of Facility Gonce Funeral Service, P.A. 4001 Ritchie Highway Baltimore, Maryland 21225		
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Metastatic Inflammatory Breast Cancer Due to (or as a consequence of): Brain metastases Leptomeningeal Carcinomatosis		Approximate Interval Between Onset and Death 1 year 1mo 1mo		
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 9 <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) 9 <input type="checkbox"/> Unknown		23d. Date of delivery Month Day Year	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown	
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No			
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M	
28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred			
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier <i>[Signature]</i> M.D.		29c. License number 654413	
29d. Date signed (Month, Day, Year) 02/04/2004		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Young Lee 3001 S. Hanover St. Baltimore MD 21225			
31. Date filed (Month, Day, Year) FEB 10 2004		32. Registrar's Signature <i>[Signature]</i>			

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23e or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene
1- For State Registrar Unpend Item #23a & 27 per me G828 2/26/04 JAS
Certificate of Death
Reg. No. 2004 03697

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

1. Decedent's Name (First, Middle, Last) Laura Marie Hooper		2. Date of Death Month FEBRUARY Day 1 Year 2004		3. Time of Death 10:33A. M	
4a. Facility Name (If not institution, give street and number) 104 OAK SPRINGS DRIVE		4b. City, Town, or Location of Death GLEN BURNIE		4c. County of Death ANNE ARUNDEL	
5. Social Security Number 213 72 7358		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 45 Yrs.	
8. Date of Birth (Month, Day, Year) July 28, 1958		9. Birthplace (State or Foreign Country) Maryland			
Usual Residence of Decedent					
10a. State Maryland		10b. County Anne Arundel		10c. City, Town or Location Glen Burnie	
10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No					
10e. Street and Number 104 Oak Spring Drive		10f. Zip Code 21060		10g. Citizen of What Country? U.S.	
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:	
14. Race - American Indian, Black, White, etc. Specify: White					
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12th College (1-4or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Waitress		16b. Kind of Business/Industry Hotel	
17. Father's Name (First, Middle, Last) Frank J. Robbins		18. Mother's Name (First, Middle, Maiden Surname) Carra P. Brooks			
19a. Informant's Name/Relationship (Type, Print) Michael Hooper / Husband		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 104 Oak Spring Drive Glen Burnie, Maryland 21060			
20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Bayview Crematory		20c. Location - City or Town, State Baltimore, Maryland	
20d. Date 2/5/2004					
21. Signature of Funeral Service Licensee 		22. Name and Address of Facility Gonce Funeral Service, P.A. 4001 Ritchie Highway Baltimore, Maryland 21225			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Chronic alcoholism Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last					
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 4 <input type="checkbox"/> Pregnant at time of death 9 <input type="checkbox"/> Unknown		23d. Date of delivery Month Day Year	
23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown					
24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No			
25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other (Specify) SCENE			
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M	
28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred			
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.					
29b. Signature and title of certifier 		29c. License number O.C.M.E.		29d. Date signed (Month, Day, Year) FEBRUARY 2, 2004	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) J. L. Aaron Locke, MD 111 Penn Street, Baltimore, Maryland 21201					
31. Date filed (Month, Day, Year) FEB 10 2004		32. Registrar's Signature 			

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2004 03698

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Arthur Hooper

2. Date of Death

February 07 2004

3. Time of Death

8-30 PM

4a. Facility Name (If not institution, give street and number)

Rock Glenn Nursing Center

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

N/A

Funeral
Director

5. Social Security Number

714-03-4073

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

99 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

JUL 23, 1904

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

N/A

10c. City, Town or Location

Baltimore

10d. Inside City Limits

☒ Yes 2 ☐ No

10e. Street and Number

10 North Rock Glen Road

10f. Zip Code

21229

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Clerk

16b. Kind of Business/Industry

Railway Express

17. Father's Name (First, Middle, Last)

Jefferson D. Hooper

18. Mother's Name (First, Middle, Maiden Surname)

Mary Byers

19a. Informant's Name/Relationship (Type, Print)

Anne Stocksdale/daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

319 Stonewall Road Catonsville, MD 21228

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Metro Crematory, Inc.

Date

2/9/04

20c. Location - City or Town, State

Baltimore, MD

21. Signature of Funeral Service Licensee

Thomas Gregor

22. Name and Address of Facility

Cremation Society of Maryland, Inc.
299 Frederick Road Baltimore, MD 21228

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Atherosclerotic Cardiovascular disease years

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Hypertension years

Due to (or as a consequence of):

c. Chronic obstructive Airway disease years

Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Amstun M. Naem MD

29c. License number

D 15503

29d. Date signed (Month, Day, Year)

February 09 2004

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Amstun M. Naem MD 501 Dolphin St, Balto, MD 21217

31. Date filed (Month, Day, Year)

FEB 10 2004

32. Registrar's Signature

[Signature]

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2004 03699

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "nature", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Physician
/Medical
ExaminerFuneral
Director

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

1. Decedent's Name (First, Middle, Last) Dorothy D. Johnson		2. Date of Death Month 02 Day 03 Year 2004		3. Time of Death 2:45 PM	
4a. Facility Name (If not institution, give street and number) Future Care Sandtown			4b. City, Town, or Location of Death Baltimore		4c. County of Death
5. Social Security Number 212-26-9072	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 83 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) 4-17-20
9. Birthplace (State or Foreign Country) MD					
10a. State MD		10b. County Baltimore		10c. City, Town or Location Baltimore	
10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No					
10e. Street and Number 1814 W. Lexington Street		10f. Zip Code 21223		10g. Citizen of What Country? USA	
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:	
14. Race - American Indian, Black, White, etc. Specify: BLACK		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 11th College (1-4or 5+)			
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Waitress		16b. Kind of Business/Industry Private Club			
17. Father's Name (First, Middle, Last) Alexander Williams			18. Mother's Name (First, Middle, Maiden Surname) Anna Pinkney		
19a. Informant's Name/Relationship (Type, Print) William Johnson Jr./son			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1814 W. Lexington St Baltimore, MD 21223		
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Garrison Va Cemetery		20c. Location - City or Town, State 2-10-04 Owings Mills, MD	
21. Signature of Funeral Service Licensee Vaughn C. Greene		22. Name and Address of Facility Vaughn C. Greene Funeral Services 8728 Liberty Rd Randallstown, MD 21133			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. CHRONIC OBSTRUCTIVE PULMONARY DISEASE Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last					Approximate Interval Between Onset and Death
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. DEMENTIA					23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Probably <input type="checkbox"/> Unknown
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No			
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M	
28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred			
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.					
29b. Signature and title of certifier UMA M.D.		29c. License number D0059107		29d. Date signed (Month, Day, Year) 02-06-2004	
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) KALU UMA WESTSIDE MEDICAL CENTER 2600 LIBERTY HEIGHTS AVENUE BALTIMORE, M.D 21215					
31. Date filed (Month, Day, Year) FEB 10 2004		32. Registrar's Signature [Signature]			

State
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2004 03700

1- For
State
Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) WILLIAM JOHNSON				2. Date of Death Month 02 Day 04 Year 04		3. Time of Death 7:00 AM	
	4a. Facility Name (If not institution, give street and number) UNIVERSITY OF MARYLAND MEDICAL SYSTEM				4b. City, Town, or Location of Death BALTIMORE, MD		4c. County of Death N/A	
Funeral Director	5. Social Security Number P18-09-1130		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 84 Yrs.		8. Date of Birth (Month, Day, Year) 07-13-1919	
	9. Birthplace (State or Foreign Country) MD		10a. State MD		10b. County N/A		10c. City, Town or Location BALTIMORE	
To Be Completed by Funeral Director	10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No				10e. Street and Number 1100 PENNSYLVANIA AVENUE		10f. Zip Code 21201	
	10g. Citizen of What Country? USA				11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates:	
To Be Completed by Physician/Medical Examiner	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: BLACK		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 6TH GRADE College (1-4 or 5+) N/A	
	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) WATER				16b. Kind of Business/Industry HOTEL			
To Be Completed by Physician/Medical Examiner	17. Father's Name (First, Middle, Last) HARRY JACKSON				18. Mother's Name (First, Middle, Maiden Surname) VIRGIE JOHNSON			
	19a. Informant's Name/Relationship (Type, Print) PEGGY HARGROVE				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6014 WOODCREST AVE, PIKESVILLE, MD 21209			
To Be Completed by Physician/Medical Examiner	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) GARRISON FOREST		20c. Location - City or Town, State OWINGS MILLS, MD	
	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility VAUGHN C. GREENE FUNERAL SERVICE 8128 LIBERTY RD., RANDALSTOWN MD 21133			
To Be Completed by Physician/Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or head failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. PNEUMONIA Due to (or as a consequence of): b. CONGESTIVE HEART FAILURE Due to (or as a consequence of): c. Due to (or as a consequence of): d.				Approximate Interval Between Onset and Death 1 WEEK 1 YEAR			
	23b. If FEMALE: Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown				23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Other (specify) <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Unknown			
To Be Completed by Physician/Medical Examiner	23d. Date of delivery Month _____ Day _____ Year _____				23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown			
	24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide				28a. Date of Injury (Month, Day Year) M			
To Be Completed by Physician/Medical Examiner	28b. Time of Injury M				28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
	28d. Describe how injury occurred				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			
To Be Completed by Physician/Medical Examiner	28f. Location (Street and Number or Rural Route Number, City or Town, State)				29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.			
	29b. Signature and title of certifier M.D.				29c. License number P17671			
To Be Completed by Physician/Medical Examiner	29d. Date signed (Month, Day, Year) 02/04/04				30. Name and address of person who completed cause of death (Item 23a) (Type, Print) NICHOLAS GALIFIANAKIS, M.D. 29 S. GREENE ST. BALTIMORE, MD 21201			
	31. Date filed (Month, Day, Year) FEB 10 2004				32. Registrar's Signature 			

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2004 03701

Certificate of Death

Reg. No.

1- For State Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) WILLIAM JOHNSON			2. Date of Death Month JANUARY Day 16 Year 2004		3. Time of Death 12:55AM	
	4a. Facility Name (If not institution, give street and number) STELLA MARIS HOSPICE			4b. City, Town, or Location of Death BALTIMORE		4c. County of Death	
Funeral Director	5. Social Security Number 214-38-4688		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 61 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth Month, Day, Year JUNE 8, 1942
	9. Birthplace (State or Foreign Country) MARYLAND		Usual Residence of Decedent				
10a. State MD		10b. County		10c. City, Town or Location BALTIMORE		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
10e. Street and Number 1537 E. 29th STREET			10f. Zip Code 21218		10g. Citizen of What Country? U.S.A.		
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: BLACK	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 10th College (1-4or 5+)			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) CAB DRIVER		16b. Kind of Business/Industry TRANSPORTATION		
17. Father's Name (First, Middle, Last) LORENZA COLEMAN				18. Mother's Name (First, Middle, Maiden Surname) EDITH MILLER			
19a. Informant's Name/Relationship (Type, Print) LILLIAN JOHNSON /wife				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1537 E. 29th St. BALTIMORE, MARYLAND 21218			
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) MT. ZION CEMETERY		Date 1-22-04		20c. Location - City or Town, State BALTIMORE, MARYLAND	
21. Signature of Funeral Service Licensee Vaughn C. Greene		22. Name and Address of Facility VAUGHN C. GREENE FUNERAL Hm 4905 YORK ROAD BALTIMORE, MD 21212					
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. prostate cancer							Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last							
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown							23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify)
23d. Date of delivery Month Day Year							
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No							24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) hospice					
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
28d. Describe how injury occurred				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			
28f. Location (Street and Number or Rural Route Number, City or Town, State)							
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.							
29b. Signature and title of certifier Dr. [Signature]				29c. License number D40854		29d. Date signed (Month, Day, Year) 2/6/2004	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) David Rosenberg 301 St. Paul Pl. Baltimore 21202							
31. Date filed (Month, Day, Year) FEB 10 2004				32. Registrar's Signature [Signature]			

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State Registrar

Certificate of Death

Reg. No.

2004 03702

1- For
State
RegistrarPhysician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Larry R. Jones Jr.

2. Date of Death

Month Day Year
FEBRUARY 6, 2004

3. Time of Death

2115 P M

4a. Facility Name (If not institution, give street and number)

5000 FREDERICK AVENUE

4b. City, Town, or Location of Death

BALTIMORE CITY

4c. County of Death

N/A

Funeral
Director

5. Social Security Number

213-90-4566

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

26 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
8-29-77

9. Birthplace (State or Foreign Country)

Baltimore, Md.

Usual Residence of Decedent

10a. State

Md.

10b. County

N/A

10c. City, Town or Location

Baltimore (Windsor Mill)

10d. Inside City Limits

☒ Yes 2 ☐ No

10e. Street and Number

7408 Brivworth Ct.

10f. Zip Code

21244

10g. Citizen of What Country?

USA

11. Marital Status

1 ☒ Never Married 2 ☐ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)
12

College (1-4or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Telecommunication

16b. Kind of Business/Industry

Metro.

17. Father's Name (First, Middle, Last)

Larry R. Jones

18. Mother's Name (First, Middle, Maiden Surname)

Bernadette Fennell

19a. Informant's Name/Relationship (Type, Print)

Bernadette Fennell Mother 1202 E. Belvedere Ave, Baltimore, Md. 21239

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Weetern Cem.

Date

2-12-04

20c. Location - City or Town, State

Baltimore, Md.

21. Signature of Funeral Service Licensee

Lloyd M. Estep

22. Name and Address of Facility

Estep Brothers Funeral Ser, P.A.
1300 Eutaw Place, Baltimore, Md. 21217

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. MULTIPLE GUNSHOT WOUNDS

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy
4 ☐ Pregnant at time of death 5 ☐ Other (Specify)
9 ☐ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy performed?
1 ☒ Yes 2 ☐ No24b. Were autopsy findings available prior to completion of cause of death?
1 ☒ Yes 2 ☐ No25. Was case referred to medical examiner?
1 ☒ Yes 2 ☐ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☒ Other (Specify) AT SCENE

27. Manner of Death

1 ☐ Natural 5 ☐ Pending investigation
2 ☐ Accident 6 ☐ Could not be determined
3 ☐ Suicide 4 ☒ Homicide

28a. Date of Injury (Month, Day Year)

2/6/04

28b. Time of Injury

9:03 P M

28c. Injury at Work?

1 ☐ Yes 2 ☒ No

28d. Describe how injury occurred

SUBJECT WAS SHOT

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

STREET

28f. Location (Street and Number or Rural Route Number, City or Town, State)

5000 Frederick Ave, Baltimore MD

29a. Certifier (Check only one)

1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Ame...

29c. License number

OCME

29d. Date signed (Month, Day, Year)

FEBRUARY 7, 2004

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ANA RVBIO, MD 111 Penn Street, Baltimore, Maryland 21201

31. Date filed (Month, Day, Year)

FEB 10 2004

32. Registrar's Signature

Ben...

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.Physician
/Medical
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2004 03703

1- For
State
Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Yulee Johns				2. Date of Death Month Day Year February 6, 2004		3. Time of Death 11:00 P M	
	4a. Facility Name (If not institution, give street and number) 1302 Howard Road				4b. City, Town, or Location of Death Glen Burnie		4c. County of Death Anne Arundel	
Funeral Director	5. Social Security Number 266-20-3456		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 79 Yrs.		8. Date of Birth (Month, Day, Year) Aug 31, 1924	
	9. Birthplace (State or Foreign Country) FL		10a. State MD		10b. County Anne Arundel		10c. City, Town or Location Glen Burnie	
To Be Completed by Funeral Director	10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		10e. Street and Number 1302 Howard Road		10f. Zip Code 21060		10g. Citizen of What Country? USA	
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: 43-46		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White	
To Be Completed by Physician/Medical Examiner	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <input type="checkbox"/> College (1-4or 5+) <input checked="" type="checkbox"/> 4		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Executive		16b. Kind of Business/Industry Westinghouse			
	17. Father's Name (First, Middle, Last) Jerome Johns				18. Mother's Name (First, Middle, Maiden Surname) Unknown			
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) Mrs. Hope Johns / Wife				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1302 Howard Road Glen Burnie, MD 21060			
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Glen Haven Memorial Park		Date Feb 10 2004		20c. Location - City or Town, State Glen Burnie, MD	
To Be Completed by Physician/Medical Examiner	21. Signature of Funeral Service Licensee <i>[Signature]</i> MO13604		22. Name and Address of Facility Singleton Funeral Home, P.A. 1 Second Avenue SW Glen Burnie, MD 21061					
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Myocardial Infarction b. Coronary Arteriosclerosis c. d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last						Approximate Interval Between Onset and Death	
To Be Completed by Physician/Medical Examiner	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Unknown		3 <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Other (specify)		23d. Date of delivery Month Day Year	
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown	
To Be Completed by Physician/Medical Examiner	24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
	26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M	
To Be Completed by Physician/Medical Examiner	28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			
	28f. Location (Street and Number or Rural Route Number, City or Town, State)		29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.					
To Be Completed by Physician/Medical Examiner	29b. Signature and title of certifier <i>[Signature]</i>		29c. License number 146815		29d. Date signed (Month, Day, Year) 02/09/2004			
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Anil Chopra, MD 7575 Ritchie Hwy Glen Burnie, MD 21061							
State Registrar	31. Date filed (Month, Day, Year) FEB 10 2004		32. Registrar's Signature <i>[Signature]</i>					

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend Item 17 per State of Maryland Department of Health and Mental Hygiene
 1- Registrar Certificate of Death Reg. No. 2004 03704

Physician
/Medical
Examiner

Funeral
Director

1. Decedent's Name (First, Middle, Last) BEATRICE JOHNSON		2. Date of Death Month FEB Day 3 Year 2004		3. Time of Death 12 15 PM	
4a. Facility Name (If not institution, give street and number) MERCY HOSPITAL		4b. City, Town, or Location of Death BALTIMORE		4c. County of Death	
5. Social Security Number 214-24-3827	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 83 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) 7-1-1920
9. Birthplace (State or Foreign Country) Md					
Usual Residence of Decedent					
10a. State Md	10b. County N/A	10c. City, Town or Location Baltimore		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
10e. Street and Number 4207 Liberty Heights Avenue		10f. Zip Code 21207		10g. Citizen of What Country? U S A	
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:	
14. Race - American Indian, Black, White, etc. Specify: Black		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 8th grade College (1-4 or 5+) N/A			
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Domestic		16b. Kind of Business/Industry Private Home			
17. Father's Name (First, Middle, Last) Charles Johnson Charles Harris			18. Mother's Name (First, Middle, Maiden Sumame) Mary Ann Baynor		
19a. Informant's Name/Relationship (Type, Print) Katherine Wilson - Daughter			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2811 Parkwood Avenue Balto, Md 21217		
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input checked="" type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) KING Memorial Park		20c. Location - City or Town, State Randallstown, Md	
21. Signature of Funeral Service Licensee <i>[Signature]</i>		22. Name and Address of Facility March F/H West 4300 Wabash Avenue Balto, Md 21215			

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) CORONARY ARTERY DISEASE		Approximate Interval Between Onset and Death YRS
a. Due to (or as a consequence of):		
b. Due to (or as a consequence of):		
c. Due to (or as a consequence of):		
d. Due to (or as a consequence of):		
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		
23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input checked="" type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <input type="checkbox"/> Unknown		23d. Date of delivery Month Day Year
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Non-insulin dependent diabetes		
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown
26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)		
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		
29b. Signature and title of certifier <i>[Signature]</i>	29c. License number D42635	29d. Date signed (Month, Day, Year) FEB 3, 2004
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) JOSEPH COSTA MD 301 ST PAUL PLACE BALTIMORE, MD 21201		
31. Date filed (Month, Day, Year) FEB 10 2004	32. Registrar's Signature <i>[Signature]</i>	

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar AMEND ITEM #18 PER FH G828 2/10/04 **Certificate of Death**

Reg. No. 2004 03705

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) SHYANN TREASURE JONES				2. Date of Death Month Day Year JANUARY 28 2004		3. Time of Death 8 32 AM	
	4a. Facility Name (If not institution, give street and number) Sinai Hospital of Baltimore				4b. City, Town, or Location of Death Baltimore		4c. County of Death N/A	
Funeral Director	5. Social Security Number 218-53-8406	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 5 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) DEC. 22, 1998		9. Birthplace (State or Foreign Country) Maryland
	Usual Residence of Decedent				10c. City, Town or Location Baltimore		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
To Be Completed by Funeral Director	10a. State Maryland	10b. County N/A	10e. Street and Number 3305 Glen Ave			10f. Zip Code 21215		10g. Citizen of What Country? USA
	11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: Black	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 0 College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) CHILD		16b. Kind of Business/Industry			
	17. Father's Name (First, Middle, Last) HAROLD JONES				18. Mother's Name (First, Middle, Maiden Surname) FLAVIA MARSHALL FLAVIA LOPEZ			
	19a. Informant's Name/Relationship (Type, Print) FLAVIA MARSHALL / MOTHER				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3305 Glen Ave Baltimore, Md 21215			
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Daniel Ridge Cemetery		20c. Location - City or Town, State Pikesville Maryland		20d. Date 2/14/04	
	21. Signature of Funeral Service Licensee <i>[Signature]</i>		22. Name and Address of Facility CHATHAM - NANCY LINDA HOME 5248 KESLER ST BALTIMORE, Maryland 21215					
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. CARDIO PULMONARY ARREST Due to (or as a consequence of): b. BRAIN TUMOUR Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last							
	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <input type="checkbox"/> Unknown				23d. Date of delivery Month Day Year	
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown	
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> VER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier DR. NDIDI NWOKORIE		29c. License number D52173		29d. Date signed (Month, Day, Year) JANUARY 28, 2004		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DR. NDIDI NWOKORIE, 2401 WEST BELVEDERE AVE, BALT., 21215								
31. Date filed (Month, Day, Year) FEB 10 2004		32. Registrar's Signature <i>[Signature]</i>						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For
State
Registrar

Amend & Unpend Item #1,23a,pt. II 27 28a-f per me G829 3/25/04

Certificate of Death

tas Reg. No.

2004 03706

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

1. Decedent's Name (First, Middle, Last) Tyquan Quan Jackson		2. Date of Death Month February Day 05 , Year 2004		3. Time of Death 2:31 A M	
4a. Facility Name (If not institution, give street and number) University of Maryland Medical Center		4b. City, Town, or Location of Death Baltimore		4c. County of Deeth N/A	
5. Social Security Number 212-69-1793		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) Yrs. 02 Months 06 Days 16	
8. Date of Birth (Month, Day, Year) 11 29 03		9. Birthplace (State or Foreign Country) MD			
10a. State MD		10b. County NA		10c. City, Town or Location Baltimore	
10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		10e. Street and Number 741 Lennox Street		10f. Zip Code 21217	
10g. Citizen of What Country? U.S.A.		11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:	
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: Black		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) N/A College (1-4or 5+) N/A	
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) N/A		16b. Kind of Business/Industry N/A		17. Father's Name (First, Middle, Last) John Jackson	
18. Mother's Name (First, Middle, Maiden Surname) Quarnoda Sellers		19a. Informant's Name/Relationship (Type, Print) Quarnoda Sellers-Mother		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 741 Lennox Street, Baltimore Md 21217	
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) King Memorial Park		20c. Location - City or Town, State 2/11/04 Randallstown, Md	
21. Signature of Funeral Service Licensee 		22. Name and Address of Facility March F/H West 4300 Wabash Ave, Baltimore Md 21215		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Sudden Unexplained Death in Infancy (SUDI) a. Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of):	
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Other (specify) <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Unknown		23d. Date of delivery Month Day Year	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Complications of Prematurity					
24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input checked="" type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year) Found 2/5/04	
28b. Time of Injury Found 1:46 a M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred Unknown	
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Found in residence		28f. Location (Street and Number or Rural Route Number, City or Town, State) 741 Lennox St. Baltimore, MD		29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.	
29b. Signature and title of certifier 		29c. License number O.C.M.E.		29d. Date signed (Month, Day, Year) February 05, 2004	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) THEODOR M King 111 Penn Street, Baltimore, Maryland 21201					
31. Date filed (Month, Day, Year) FEB 10 2004		32. Registrar's Signature 			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene
 AMEND ITEM #27 PER FH G828 2/10/04
 AMEND ITEM #17 PER FH G828 2/10/04
 Certificate of Death
 Reg. No. 2004 03707

Physician
/Medical
Examiner

Funeral
Director

1. Decedent's Name (First, Middle, Last) Sylvester Jones		2. Date of Death Month 01 Day 26 Year 04		3. Time of Death 1:45 A M	
4a. Facility Name (If not institution, give street and number) University of Maryland Hospital Baltimore		4b. City, Town, or Location of Death Baltimore City		4c. County of Death Baltimore City	
5. Social Security Number 218-16-7776		6. Sex 1 M 2 F		7. Age (In yrs. last birthday) 71 Yrs.	
8. Date of Birth (Month, Day, Year) 9-7-22		9. Birthplace (State or Foreign Country) MARYLAND		10. Inside City Limits 1 Yes 2 No	
10a. State MARYLAND		10b. County		10c. City, Town or Location Baltimore city	
10d. Street and Number 3421 Cayon Ave.		10f. Zip Code 21229		10g. Citizen of What Country? USA	
11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No		13. Was Decedent of Hispanic Origin? (Specify Yes or No) 1 Yes 2 No	
14. Race - American Indian, Black, White, etc. Specify: BLACK		15. Decedent's Education (Specify only highest grade completed) 10th		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Chef	
16b. Kind of Business/Industry Food Service		17. Father's Name (First, Middle, Last) Edgar Jones		18. Mother's Name (First, Middle, Maiden Surname) Mauve Douglass	
19a. Informant's Name/Relationship (Type, Print) Larve Davis (Niece)		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3913 Shannon Drive Balto, Md.			
20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Voshell Cemetery		20c. Location - City or Town, State BALTO. MD	
21. Signature of Funeral Service Licensee [Signature]		22. Name and Address of Facility Miller's Metropolitan Chapel Balto. Md.			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. myocardial infarction		23b. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify)		23c. Date of delivery Month Day Year	
23d. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown		24a. Was an autopsy performed? 1 Yes 2 No	
24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No		25. Was case referred to medical examiner? 1 Yes 2 No		26. Place of Death (Check only one) 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify)	
27. Manner of Death 1 Natural 2 Accident 3 Suicide 4 Homicide 5 Pending investigation 6 Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M	
28c. Injury at Work? 1 Yes 2 No		28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	
28f. Location (Street and Number or Rural Route Number, City or Town, State)		29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.			
29b. Signature and title of certifier [Signature]		29c. License number P 14653		29d. Date signed (Month, Day, Year) 01/26/04	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Bebvon K. Martin, M.D. 22 S. Greene St., Baltimore, MD 21201					
31. Date filed (Month, Day, Year) FEB 10 2004		32. Registrar's Signature [Signature]			

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2004 03708

1- For
State
RegistrarPhysician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

HERBERT G KNIGHT

2. Date of Death

2/4/04

3. Time of Death

3:06p^M

4a. Facility Name (If not institution, give street and number)

800 Beaumont Avenue

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

Funeral
Director

5. Social Security Number

212-22-4561

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

75

8. Date of Birth

11/14/28

9. Birthplace (State or Foreign Country)

North Carolina

Usual Residence of Decedent

10a. State

MD

10b. County

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

800 Beaumont Avenue

10f. Zip Code

21212

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☒ Yes 2 ☐ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

8th

College (1-4or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Equipment Operator Industrial

16b. Kind of Business/Industry

Industrial

17. Father's Name (First, Middle, Last)

George Knight

18. Mother's Name (First, Middle, Maiden Surname)

Mary Hewlin

19a. Informant's Name/Relationship (Type, Print)

Alice Knight (Wife)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

800 Beaumont Ave, Balt MD 21212

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Garrison Forest Cemetery

Date

2/4/04

20c. Location - City or Town, State

Owings Mills, MD

21. Signature of Funeral Service Licensee

Vaughn Greene

22. Name and Address of Facility

Vaughn C. Greene Funeral Services
4905 York Rd. Balt MD 21212

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Metastatic NSCLCA

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

2 YEARS

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☒ No
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 5 ☐ Ectopic pregnancy
9 ☐ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Hospice

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☒ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Aida Andriollo-Espinoza MD

29c. License number

MDX-AU4635427

29d. Date signed (Month, Day, Year)

February 06, 2004

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

AIDA ANDRIOLLO-ESPINOZA

Greenbaum Cancer Center, Baltimore MD

31. Date filed (Month, Day, Year)

FEB 10 2004

32. Registrar's Signature

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, a Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2004 03709

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Robert Kimble

2. Date of Death

February 5, 2004

3. Time of Death

4:43 AM

4a. Facility Name (If not institution, give street and number)

Mercy Hospital

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

N/A

Funeral
Director

5. Social Security Number

214-76-3755

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

42

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

12-13-61

9. Birthplace (State or Foreign Country)

New York, City

Usual Residence of Decedent

10a. State

Md.

10b. County

AACO.

10c. City, Town or Location

Severna

10d. Inside City Limits

☒ Yes ☐ No

10e. Street and Number

821478 Stewarton Ct.

10f. Zip Code

20144

10g. Citizen of What Country?

USA

11. Marital Status

☐ Never Married ☐ Married
☐ Widowed ☒ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

☐ Yes ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

☐ Yes ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Cab Driver

16b. Kind of Business/Industry

Cab Co.

17. Father's Name (First, Middle, Last)

Robert Kimble

18. Mother's Name (First, Middle, Maiden Surname)

Martha Pindell

19a. Informant's Name/Relationship (Type, Print)

Renee Spencer (S)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

102 Cherry Lane, Glen Burnie, Md. 21040

20a. Method of Disposition

☒ Burial ☐ Cremation ☐ Removal from State
☐ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Mt. Zion Cem.

Date

2-13-04

20c. Location - City or Town, State

Lansdowne, Md.

21. Signature of Funeral Service Licensee

Lloyd M. Ester

22. Name and Address of Facility

Ester Brothers Funeral Ser, P.A.
1300 Eutaw Place, Baltimore, Md. 21217

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Acquired Immune Deficiency Syndrome
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☒ No ☐ Probably ☐ Unknown

24a. Was an autopsy performed?

☐ Yes ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

☐ Yes ☒ No

25. Was case referred to medical examiner?

☐ Yes ☒ No

26. Place of Death (Check only one)

Hospital:

☐ Inpatient ☐ ER/Outpatient ☐ DOA

Other:

☐ Nursing Home ☐ Residence ☒ Other (Specify) hospice

27. Manner of Death

☒ Natural ☐ Pending investigation
☐ Accident ☐ Could not be determined
☐ Suicide ☐ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

☐ Yes ☒ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Dr. [Signature]

29c. License number

D40854

29d. Date signed (Month, Day, Year)

2/6/2004

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

David, Riseberg 301 ST PAUL PL Baltimore 21202

31. Date filed (Month, Day, Year)

FEB 10 2004

32. Registrar's Signature

[Signature]

State
Registrar

ORIGINAL

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Robert Kimble 2/5/04 4:43 PM

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2004 03710

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last) Teresa Principe Klein 2. Date of Death Month February 4th, 2004 3. Time of Death 5:05 PM

4a. Facility Name (If not institution, give street and number) North Arundel Hospital 4b. City, Town, or Location of Death Glen Burnie 4c. County of Death Anne Arundel

Funeral
Director

5. Social Security Number 151-10-5097 6. Sex 1 ☐ M 2 ☒ F 7. Age (In yrs. last birthday) 83 Yrs. 8. Date of Birth (Month, Day, Year) May 28, 1920 9. Birthplace (State or Foreign Country) NY

Usual Residence of Decedent

10a. State MD 10b. County Anne Arundel 10c. City, Town or Location Glen Burnie 10d. Inside City Limits 1 ☐ Yes 2 ☒ No

10e. Street and Number 1134 Wynbrook Road 10f. Zip Code 21060 10g. Citizen of What Country? USA

11. Marital Status 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No Specify: 14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Accountant 16b. Kind of Business/Industry Oil Company

17. Father's Name (First, Middle, Last) John Principe 18. Mother's Name (First, Middle, Maiden Surname) Marie Choida

19a. Informant's Name/Relationship (Type, Print) Ms. Kathleen Klein / Daughter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5385 Broadwater Lane Clarksville, MD 21029-1119

20a. Method of Disposition 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 20b. Place of Disposition (Name of cemetery, crematory or other place) Glen Haven Memorial Park 20c. Location - City or Town, State Feb 7 2004 Glen Burnie, MD

21. Signature of Funeral Service Licensee [Signature] 22. Name and Address of Facility Singleton Funeral Home, P.A. 1 Second Avenue SW Glen Burnie, MD 21061

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Congestive Heart Failure Due to (or as a consequence of): b. Acute myocardial infarction Due to (or as a consequence of): c. Diabetes Due to (or as a consequence of): d. { Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No 26. Place of Death (Check only one) Hospital: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined 28a. Date of Injury (Month, Day Year) 28b. Time of Injury M 28c. Injury at Work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) 1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier [Signature] MD 29c. License number D48006 29d. Date signed (Month, Day, Year) February 4th, 2004

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) KOFI BOHATEY, 301 Hospital Dr., Glen Burnie, MD

31. Date filed (Month, Day, Year) FEB 10 2004 32. Registrar's Signature [Signature]

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760, Teresa Klein

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2004 03711

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Sylvia A. LYNN

2. Date of Death

FEBRUARY 9, 2004 6:45 AM

3. Time of Death

6:45 AM

4a. Facility Name (If not institution, give street and number)

Mercy Hospital

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

Funeral
Director

5. Social Security Number

213-30-4533

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

69

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

4/25/34

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State
MD

10b. County

10c. City, Town or Location

TOWSON

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

14 Aigburth Road

10f. Zip Code

21286

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

2 years

16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Director

16b. Kind of Business/Industry

Recreation Center

17. Father's Name (First, Middle, Last)

Arthur Thomas

18. Mother's Name (First, Middle, Maiden Surname)

Bertha Crippen

19a. Informant's Name/Relationship (Type, Print)

Charmaine Cooper (Daughter)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2004 Ruxton Ave, Balto. MD 21216

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Druid Ridge Cemetery 2/13/04 Balto. MD.

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

Fun. W. Smith

22. Name and Address of Facility

Valdwin C. Greene Funeral Services
4905 York Rd. Balto. MD 21212

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Due to (or as a consequence of):
peripheral vascular disease

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

end stage renal disease

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☒ Other (Specify) hospice

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Dr. M. J.

29c. License number

D40854

29d. Date signed (Month, Day, Year)

2/4/2004

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

David, Riseberg 301 ST PAUL PL Baltimore 21202

31. Date filed (Month, Day, Year)

FEB 10 2004

32. Registrar's Signature

Fun. W. Smith

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar Amend Item #20bperFHG828 2/10/04 EW Certificate of Death

Reg. No.

2004 03712

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Franklin Lassiter Jr.		2. Date of Death Month February Day 2 Year 2004		3. Time of Death 834p M
	4a. Facility Name (If not institution, give street and number) Maryland General Hospital		4b. City, Town, or Location of Death Baltimore		4c. County of Death
Funeral Director	5. Social Security Number 219-28-1615	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (in yrs. last birthday) 71 Yrs.	8. Date of Birth (Month, Day, Year) 07 12 32	9. Birthplace (State or Foreign Country) NC
	Usual Residence of Decedent				
To Be Completed by Funeral Director	10a. State MD	10b. County NA	10c. City, Town or Location Baltimore		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
	10e. Street and Number 1444 Clairidge Road		10f. Zip Code 21207		10g. Citizen of What Country? U.S.A.
	11. Marital Status 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:
	14. Race - American Indian, Black, White, etc. Specify: Black		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12th grade College (1-4 or 5+) na		
To Be Completed by Physician/Medical Examiner	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Truck Driver		16b. Kind of Business/Industry Trucking Company		
	17. Father's Name (First, Middle, Last) Franklin Lassiter Sr.		18. Mother's Name (First, Middle, Maiden Surname) Ida Wafers		
	19a. Informant's Name/Relationship (Type, Print) Tracy Lassiter-Granddaughter		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1501 Barrett Road, Baltimore Md 21207		
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Date St. Thomas Cemetery 2/7/2004 King Memorial Park 2/6/04		
21. Signature of Funeral Service licensee <i>[Signature]</i>		22. Name and Address of Facility March F/H West 4300 Wabash Ave, Baltimore Md 21215			
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Intracerebral Hemorrhage Due to (or as a consequence of): Hypertension Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):				
	23b. IF FEMALE: Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown				
	23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) 9 <input type="checkbox"/> Unknown				
	23d. Date of delivery Month Day Year				
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.					
23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown					
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No					
24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No					
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No			
28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			
28f. Location (Street and Number or Rural Route Number, City or Town, State)					
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.					
29b. Signature and title of certifier <i>[Signature]</i> MD		29c. License number 89509		29d. Date signed (Month, Day, Year) 2/2/04	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Syed Raza, MD % Maryland General Hospital					
31. Date filed (Month, Day, Year) FEB 10 2004		32. Registrar's Signature <i>[Signature]</i>			

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2004 03713

1- For State Registrar

Physician / Medical Examiner	1. Decedent's Name (First, Middle, Last) ROBERT JAMES LAIRD			2. Date of Death Month Day Year February 6, 2004		3. Time of Death 11:30 P.M.	
	4a. Facility Name (If not institution, give street and number) Gilchrist Center			4b. City, Town, or Location of Death Towson		4c. County of Death Baltimore	
Funeral Director	5. Social Security Number 214-26-8272		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 75 Yrs.		8. Date of Birth (Month, Day, Year) Oct. 19, 1928	
	9. Birthplace (State or Foreign Country) Maryland						
To Be Completed by Funeral Director	Usual Residence of Decedent						
	10a. State Maryland	10b. County Baltimore	10c. City, Town or Location Towson			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	10e. Street and Number 520 Yarmouth Road			10f. Zip Code 21286		10g. Citizen of What Country? U.S.A.	
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: WWII		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12)		College (1-4or 5+) 4 years		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Chief Deputy Director		16b. Kind of Business/Industry State Lottery
	17. Father's Name (First, Middle, Last) Frank Leslie Laird			18. Mother's Name (First, Middle, Maiden Surname) Selma Marie Herzog			
	19a. Informant's Name/Relationship (Type, Print) Lillian L. Laird (wife)			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 520 Yarmouth Road Towson, Maryland 21286			
	20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Green Mount Crematory 2-9-04		Date Baltimore, Maryland		20c. Location - City or Town, State
	21. Signature of Funeral Service Licensee <i>George Fennan</i>			22. Name and Address of Facility Mitchell-Wiedefeld Funeral Home, Inc. 6500 York Rd. Baltimore, Maryland 21212			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. <i>POSTMORTEM CANCER</i> Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Approximate Interval Between Onset and Death <i>years</i>						
23b. IF FEMALE: Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown							
23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Other (specify) <input checked="" type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Unknown							
23d. Date of delivery Month Day Year							
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Probably <input type="checkbox"/> Unknown							
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No							
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No							
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) <i>hospice</i>					
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28d. Describe how injury occurred			
		28f. Location (Street and Number or Rural Route Number, City or Town, State)					
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.							
29b. Signature and title of certifier <i>[Signature]</i> MD		29c. License number D 58303		29d. Date signed (Month, Day, Year) February 7, 2004			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <i>Ann J. Charles, MD 6601 N Charles St Baltimore MD 21204</i>							
31. Date filed (Month, Day, Year) FEB 10 2004		32. Registrar's Signature <i>[Signature]</i>					

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician / Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2004 03714

1- For
State
RegistrarPhysician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

John Charles Lukaszczyk

2. Date of Death

February 4 2004

3. Time of Death

4:00 P. M.

4a. Facility Name (If not institution, give street and number)

4120 Duane Avenue Apt. 1

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

N/A

Funeral
Director

5. Social Security Number

191 18 9605

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

80 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

May 8, 1923

9. Birthplace (State or Foreign Country)

Pennsylvania

Usual Residence of Decedent

10a. State

Maryland

10b. County

N/A

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

4120 Duane Avenue Apt. 1

10f. Zip Code

21225

10g. Citizen of What Country?

U.S.

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☒ Yes 2 ☐ No
If Yes, Give Year or Dates: WW II

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)
8th

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Truck Driver

16b. Kind of Business/Industry

Anne Arundel County

17. Father's Name (First, Middle, Last)

Joseph Lukaszczyk

18. Mother's Name (First, Middle, Maiden Surname)

Kunedunda Shuba

19a. Informant's Name/Relationship (Type, Print)

Helen Lukaszczyk / wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

4120 Duane Avenue Apt. 1 Baltimore, Maryland 21225

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

MD State Veteran Cem.

Date

2/9/2004

20c. Location - City or Town, State

Crownsville, Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Gonce Funeral Service, P.A.
4001 Ritchie Highway Baltimore, Maryland 21225

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. Enter only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Cerebral Vascular Accident

Due to (or as a consequence of):

b. Bifurcated Cerebral Vascular Disease

Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☐ No
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown3 ☐ Ectopic pregnancy5 ☐ Other (specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation
2 ☐ Accident 6 ☐ Could not be determined
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number

D09732

29d. Date signed (Month, Day, Year)

2/5/04

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MARIO J. RIEDA MD. 4211 42nd ST BALTO MD 21225

31. Date filed (Month, Day, Year)

32. Registrar's Signature

FEB 10 2004

ORIGINAL

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
ExaminerTo the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

671

State
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2004 03715

1- For State Registrar

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Baltimore Salomon Marquina

2. Date of Death

Month

Day

Year

FEB.

8

2004

3. Time of Death

0301 AM

4a. Facility Name (If not institution, give street and number)

NEW HAMPSHIRE AVENUE @ MERWOOD DRIVE

4b. City, Town, or Location of Death

TAKOMA PARK

4c. County of Death

MONTGOMERY

Funeral
Director

5. Social Security Number

6. Sex ☒ M ☐ F

7. Age (in yrs. last birthday)

32 Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth (Month, Day, Year)

05/17/71

9. Birthplace (State or Foreign Country)

El Salvador

Usual Residence of Decedent

10a. State

DC

10b. County

10c. City, Town or Location

Washington

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

3132 16th Street NW

10f. Zip Code

20010

10g. Citizen of What Country?

El Salvador

11. Marital Status

☒ Never Married 2 ☐ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

☒ Yes 2 ☐ No Specify: Salvadorian

14. Race - American Indian, Black, White, etc.

Specify: white

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4or 5+)

2nd

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Maintenance

16b. Kind of Business/Industry

Extra Clean Inc

17. Father's Name (First, Middle, Last)

unk

18. Mother's Name (First, Middle, Maiden Sumame)

Maria Erlinda Martinez

19a. Informant's Name/Relationship (Type, Print)

Erlinda Marquina (sis)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

3132 16th Street NW, Wash. DC 20010

20a. Method of Disposition

1 ☐ Burial 2 ☐ Cremation 3 ☒ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Lallunon

Date

02/18/04

20c. Location - City or Town, State

El Salvador

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Austin Royster funeral Home
3821 14th Street NW, Wash. DC

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Multiple injuries

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☐ No9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death4 ☐ Pregnant at time of death9 ☐ Unknown3 ☐ Ectopic pregnancy5 ☐ Other (specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☒ Yes 2 ☐ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☒ Yes 2 ☐ No

25. Was case referred to medical examiner?

☒ Yes 2 ☐ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☒ Other (Specify) AT SCENE

27. Manner of Death

1 ☐ Natural2 ☒ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

2-8-04

28b. Time of Injury

2:59 A M

28c. Injury at Work?

1 ☐ Yes 2 ☒ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Road

28d. Describe how injury occurred

occupant of car that collided with another car

28f. Location (Street and Number or Rural Route Number, City or Town, State)

@ merwood drive Takoma Park MD

29a. Certifier (Check only one)

1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated.2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number

O.C.M.E

29d. Date signed (Month, Day, Year)

FEB. 8, 2004

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

LING LI. MD

111 Penn Street, Baltimore, Maryland 21201

31. Date filed (Month, Day, Year)

FEB 10 2004

32. Registrar's Signature

State
Registrar

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2004 03716

1- For
State
Registrar

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Mary Rose Mazza				2. Date of Death Month Day Year February 1 2004				3. Time of Death 4:30A ^M	
	4a. Facility Name (If not institution, give street and number) Carroll County General Hospital				4b. City, Town, or Location of Death Westminster				4c. County of Death Carroll	
Funeral Director	5. Social Security Number 218-01-5219		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 83 Yrs.		8. Date of Birth (Month, Day, Year) Oct 15, 1920		9. Birthplace (State or Foreign Country) Maryland	
	Usual Residence of Decedent									
To Be Completed by Funeral Director	10a. State Maryland		10b. County Carroll		10c. City, Town or Location Finksburg				10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
	10e. Street and Number 1705 Fawn Way				10f. Zip Code 21048		10g. Citizen of What Country? U.S.A.			
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 4 College (1-4 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker			16b. Kind of Business/Industry Own Home		
	17. Father's Name (First, Middle, Last) Samuel Cucina				18. Mother's Name (First, Middle, Maiden Surname) Anna Baygone					
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) Lonnie D. Mazza (Son)				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1705 Fawn Way Finksburg, Maryland 21048					
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Meadowridge		Date 2-4-2004		20c. Location - City or Town, State Elkridge, Maryland			
	21. Signature of Funeral Service Licensee <i>Bernard Balowicki</i>				22. Name and Address of Facility Witzke Funeral Home of Catonsville, Inc. 1630 Edmondson Avenue Catonsville, MD 21228					
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. a. <i>Acute Myocardial Infarction</i> Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of):									
	23b. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Pneumonia, Diabetes</i>									
To Be Completed by Physician/Medical Examiner	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 9 <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 4 <input type="checkbox"/> Pregnant at time of death 9 <input type="checkbox"/> Unknown		3 <input type="checkbox"/> Ectopic pregnancy 5 <input type="checkbox"/> Other (specify)		23d. Date of delivery Month Day Year			
	24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No					
	25. Manner of Death 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		27. Date of Injury (Month, Day Year)		27b. Time of Injury M 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		27c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
	28a. Date of Injury (Month, Day Year)		28b. Time of Injury M 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred			
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)		29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.					
State Registrar	29b. Signature and title of certifier <i>Robert N. Kass</i>				29c. License number D34298		29d. Date signed (Month, Day, Year) 2-1-2004			
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Robert N. Kass, MD 532 Baltimore Blvd #201 Westminster, MD 21157									
31. Date filed (Month, Day, Year) FEB 10 2004		32. Registrar's Signature <i>Sam B. Spivey</i>								

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

1- For
State
Registrar

2004 03717

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

1. Decedent's Name (First, Middle, Last) MINNIE A. MASON		2. Date of Death Month Day Year FEBRUARY 4, 2004		3. Time of Death M 7:00A	
4a. Facility Name (If not institution, give street and number) VILLA SAINT MICHAELS		4b. City, Town, or Location of Death BALTIMORE		4c. County of Death N/A	
5. Social Security Number 214-22-4012	6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 94 Yrs.	8. Date of Birth (Month, Day, Year) 05-01-1909		9. Birthplace (State or Foreign Country) NC
Usual Residence of Decedent					
10a. State MD	10b. County N/A	10c. City, Town or Location BALTIMORE		10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No	
10e. Street and Number 4800 SETON DRIVE		10f. Zip Code 21207		10g. Citizen of What Country? USA	
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:	
14. Race - American Indian, Black, White, etc. Specify: BLACK		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4or 5+)			
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) WESTERN ELECTRIC		16b. Kind of Business/Industry ASSEMBLY			
17. Father's Name (First, Middle, Last) ROBERT ALLEN		18. Mother's Name (First, Middle, Maiden Surname) MARTHA WILLIAMS			
19a. Informant's Name/Relationship (Type, Print) SOLOMON HARP III, SON		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10601 GREENMOUNTAIN CIR, COLUMBIA, MD 21044			
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) DRUID RIDGE		20c. Location - City or Town, State 02-09-04 OWING MILLS, MD	
21. Signature of Funeral Service Licensee 		22. Name and Address of Facility HOWELL FUNERAL HOME 4600 LIBERTY HGHTS AVE, BALTO, MD 21207			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Aspiration pneumonia Due to (or as a consequence of): Hypertension Due to (or as a consequence of): Septicemia Due to (or as a consequence of): Chronic leg Ulcer					Approximate Interval Between Onset and Death 1wk 3yrs 3months 1yr
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) 9 <input type="checkbox"/> Unknown		23d. Date of delivery Month Day Year	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Dementia Dysphagia					23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M	
28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred			
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.					
29b. Signature and title of certifier  MD Physician		29c. License number D56950		29d. Date signed (Month, Day, Year) February 5, 2004	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Nnaemeka Agajelu 7445 E Furnace Branch Rd, Glen Burnie MD 21060					
31. Date filed (Month, Day, Year) FEB 10 2004		32. Registrar's Signature 			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2004 03718

1- For
State
RegistrarPhysician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

REBECCA S. MCCARTHY

2. Date of Death

Month
02Day
05Year
043. Time of Death
9:43 AMFuneral
Director

4a. Facility Name (If not institution, give street and number)

MERCY MEDICAL CENTER

4b. City, Town, or Location of Death

BALTIMORE

4c. County of Death

N/A

5. Social Security Number

234-90-4758

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

46

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth (Month, Day, Year)

March 17, 1957

9. Birthplace (State or Foreign Country)

West Virginia

Usual Residence of Decedent

10a. State

Maryland

10b. County

Baltimore

10c. City, Town or Location

Dundalk

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

8027 Wallace Road

10f. Zip Code

21222

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4or 5+)

4 Years

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Office Manager

16b. Kind of Business/Industry

T. R. Klein

17. Father's Name (First, Middle, Last)

Ernest Arthur Stewart, Sr.

18. Mother's Name (First, Middle, Maiden Surname)

Betty J. Saylor

19a. Informant's Name/Relationship (Type, Print)

Mr. Justin McCarthy (Husband)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

8027 Wallace Road Dundalk, Maryland 21222

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Blue Ridge Mem. Gdns. 2/11/2004

Date

20c. Location - City or Town, State

Beckley, West Virginia

21. Signature of Funeral Service Director

22. Name and Address of Facility

Duda-Ruck Funeral Home of Dundalk, Inc.
7922 Wise Ave. Dundalk, Maryland 21222

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. CERVICAL CANCER

Due to (or as a consequence of):

Approximate Interval Between Onset and Death
6 YEARS

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☒ No
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy
4 ☐ Pregnant at time of death 5 ☐ Other (Specify)
9 ☐ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy performed?
1 ☐ Yes 2 ☒ No24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No25. Was case referred to medical examiner?
1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

M.D.

29c. License number

D43934.

29d. Date signed (Month, Day, Year)

2/5/2004

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DWAYNE D. IM, M.D. 227 ST. PAUL PLACE BALTIMORE MD 21202

31. Date filed (Month, Day, Year)

FEB 10 2004

32. Registrar's Signature

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
ExaminerTo the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

1- For
State
Registrar

2004 03719

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <i>Louise MILLER</i>					2. Date of Death Month <i>FEBRUARY</i> Day <i>4</i> Year <i>2004</i>		3. Time of Death <i>5:20 AM</i>		
	4a. Facility Name (If not institution, give street and number) <i>Mary Medical Center</i>					4b. City, Town, or Location of Death <i>BALTIMORE</i>		4c. County of Death <i>BALTIMORE</i>		
Funeral Director	5. Social Security Number <i>211-12-6495</i>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <i>80</i> Yrs.		8. Date of Birth (Month, Day, Year) <i>June 15, 1923</i>		9. Birthplace (State or Foreign Country) <i>Pennsylvania</i>	
	Usual Residence of Decedent									
10a. State <i>Maryland</i>		10b. County <i>n/a</i>		10c. City, Town or Location <i>Baltimore</i>				10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
10e. Street and Number <i>6400 Everall Ave. Apt 410</i>					10f. Zip Code <i>21206</i>		10g. Citizen of What Country? <i>United States</i>			
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <i>White</i>		
15. Decedent's Education (Specify only highest grade completed) <i>Elementary/Secondary (0-12)</i> <i>12 yrs.</i>					16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <i>Seamstress</i>			16b. Kind of Business/Industry <i>Clothing</i>		
17. Father's Name (First, Middle, Last) <i>Raymond Biller</i>					18. Mother's Name (First, Middle, Maiden Surname) <i>Hilda Y. Yahner</i>					
19a. Informant's Name/Relationship (Type, Print) <i>Mr. Charles F. Miller / Son</i>					19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>111 Baltimore Street Aberdeen, Maryland 21001</i>					
20a. Method of Disposition <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input checked="" type="checkbox"/> Donation <input checked="" type="checkbox"/> Other (Specify) <i>Entombment</i>			20b. Place of Disposition (Name of cemetery, crematory or other place) <i>Woodlawn Cemetery</i>		Date <i>Feb. 7, 2004</i>		20c. Location - City or Town, State <i>Woodlawn, Maryland</i>			
21. Signature of Funeral Service Licensee <i>Michael E. Canapp</i>			22. Name and Address of Facility <i>Leonard J. Ruck, Inc. 5305 Harford Road Baltimore, MD 21214</i>							
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) <i>a. Metastatic Adenocarcinoma</i> Due to (or as a consequence of): <i>b. Ventricular Tachycardia</i> Due to (or as a consequence of): <i>c.</i> Due to (or as a consequence of): <i>d.</i>										
Approximate Interval Between Onset and Death <i>Unknown</i> <i>1 day</i>										
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown			23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <input type="checkbox"/> Unknown				23d. Date of delivery Month Day Year			
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown			
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No							
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide			28a. Date of Injury (Month, Day Year)		28b. Time of Injury <i>M</i>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred	
28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)							
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.										
29b. Signature and title of certifier <i>[Signature]</i>					29c. License number <i>D5036</i>		29d. Date signed (Month, Day, Year) <i>FEBRUARY 7 2004</i>			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <i>JUDITH BOWMAN 30157 PAUL PL BALTIMORE, MD 21201</i>										
31. Date filed (Month, Day, Year) <i>FEB 10 2004</i>			32. Registrar's Signature <i>[Signature]</i>							

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2004 03720

Certificate of Death

Reg. No.

1- For State Registrar

Physician / Medical Examiner	1. Decedent's Name (First, Middle, Last) Melissa Anne Martin		2. Date of Death Month: February Day: 4 Year: 2004		3. Time of Death 1:55 PM
	4a. Facility Name (If not institution, give street and number) SINAI HOSPITAL OF BALTIMORE		4b. City, Town, or Location of Death BALTIMORE CITY		4c. County of Death N/A
Funeral Director	5. Social Security Number 219-84-6645	6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. / last birthday) 34 Yrs.	8. Date of Birth (Month, Day, Year) Oct. 29, 1969	9. Birthplace (State or Foreign Country) Maryland
	Usual Residence of Decedent				
To Be Completed by Funeral Director	10a. State Maryland	10b. County N/A	10c. City, Town or Location Baltimore		10d. Inside City Limits <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No
	10e. Street and Number 2434 Belvedere Avenue		10f. Zip Code 21215		10g. Citizen of What Country? USA
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:
	14. Race - American Indian, Black, White, etc. Specify: White		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12): 10 College (1-4 or 5+)		
	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Nurses Aid		16b. Kind of Business/Industry Medical		
Physician / Medical Examiner	17. Father's Name (First, Middle, Last) Joseph McArdle		18. Mother's Name (First, Middle, Maiden Surname) Sharon Conolley		
	19a. Informant's Name/Relationship (Type, Print) Sharon McArdle Mother		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4 Sunny Meadow Ct. 302 Baltimore, Maryland 21209		
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Pine Grove Cemetery		20c. Location - City or Town, State Mt. Airy, Maryland
	21. Signature of Funeral Service Licensee Lynn B. Henss		22. Name and Address of Facility Burgee-Henss-Seitz Funeral Home, Inc. 21211 3631 Falls Road, Baltimore, Maryland		
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Sepsis Due to (or as a consequence of): b. pneumonia Due to (or as a consequence of): c. Due to (or as a consequence of): d. Approximate Interval Between Onset and Death 14 days 14 days				
Medical Certification: To Be Completed by Physician/Medical Examiner	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 9 <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 4 <input type="checkbox"/> Pregnant at time of death 9 <input type="checkbox"/> Unknown		23d. Date of delivery Month Day Year
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown
	24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death Check only one Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year) 28b. Time of Injury M 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		28d. Describe how injury occurred 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.					
29b. Signature and title of certifier Kamran Malik Jackson, MD		29c. License number RES - 444		29d. Date signed (Month, Day, Year) February 4, 2004	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) KAMRAN MALIK JACKSON, MD SINAI HOSPITAL OF BALTIMORE					
31. Date filed (Month, Day, Year) FEB 10 2004		32. Registrar's Signature [Signature]			

Patent Known AS MARTIN, MELISSA
Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2004 03721

1- For
State
RegistrarPhysician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

JOSEPH EUGENE McKENZIE

2. Date of Death

Month Day Year
FEBRUARY 4, 2004

3. Time of Death

8:00 P M

4a. Facility Name (If not institution, give street and number)

8219 OLD JUMPERS HOLE ROAD

4b. City, Town, or Location of Death

MILLERSVILLE

4c. County of Death

ANNE ARUNDEL

Funeral
Director

5. Social Security Number

212-22-9981

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

76 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
9/11/1927

9. Birthplace (State or Foreign Country)

JOHNSTOWN, PA

Usual Residence of Decedent

10a. State

MD

10b. County

ANNE ARUNDEL

10c. City, Town or Location

MILLERSVILLE

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

8219 OLD JUMPERS HOLE ROAD

10f. Zip Code

21108

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)
12

College (1-4or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

CARPENTER

16b. Kind of Business/Industry

SELF EMPLOYED

17. Father's Name (First, Middle, Last)

LEONARD McKENZIE

18. Mother's Name (First, Middle, Maiden Surname)

EDNA SMITH

19a. Informant's Name/Relationship (Type, Print)

ROSA M. McKENZIE - WIFE

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

8219 OLD JUMPERS HOLE ROAD, MILLERSVILLE, MD 21108

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

GLEN HAVEN MEM. PK.

Date

2/7/2004

20c. Location - City or Town, State

GLEN BURNIE, MD

21. Signature of Funeral Service Provider

KELLY GREGORY FINK #MO1148

22. Name and Address of Facility

FINK FUNERAL HOME, PA

426 CRAIN HIGHWAY S., GLEN BURNIE, MD 21061

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Due to (or as a consequence of):

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☐ No
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown3 ☐ Ectopic pregnancy
5 ☐ Other (specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Chronic Obstructive Lung Disease

23e. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation
6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

M.D.

29c. License number

DS0470

29d. Date signed (Month, Day, Year)

2/5/04

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

SRIDHAR ATTURU ; 8109 Ritchie Hwy Pasadena MD 21122

State Registrar

31. Date filed (Month, Day, Year)

FEB 10 2004

32. Registrar's Signature

[Signature]

ORIGINAL

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Reginald McKoy
04-0819
AKG

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2004 03722

1- For State Registrar **Unpend Item #23a, 27, 28a-f, Per ME, 03/04/04**

Reg. No.

3142

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial transit

To Be Completed by Funeral Director

Medical Certification; To Be Completed by Physician/Medical Examiner

1. Decedent's Name (First, Middle, Last) Reginald McKoy		2. Date of Death Month January Day 30 , Year 2004		3. Time of Death 17:52P^M	
4a. Facility Name (If not institution, give street and number) Good Samaritan Hospital		4b. City, Town, or Location of Death Baltimore		4c. County of Death N/A	
5. Social Security Number 218-789691		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 42 Yrs.	
8. Date of Birth (Month, Day, Year) 1-27-61		9. Birthplace (State or Foreign Country) Baltimore, Md.			
10a. State Md.		10b. County N/A		10c. City, Town or Location Baltimore	
10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		10e. Street and Number 528 W. Preston St.		10f. Zip Code 21201	
10g. Citizen of What Country? USA		11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: 80-81	
13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: Black		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+)	
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Odd Job		16b. Kind of Business/Industry Odd Job		17. Father's Name (First, Middle, Last) Carlton E. McCoy	
18. Mother's Name (First, Middle, Maiden Surname) Annie McCoy		19a. Informant's Name/Relationship (Type, Print) Tonya McCoy Sister		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1811 N. Bourne Rd, Baltimore, Maryland 21239	
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Md. Vet. Garrison Forest		20c. Location - City or Town, State Owings Mills, Md.	
21. Signature of Funeral Service Licensee Lloyd M. Estep		22. Name and Address of Facility Estep Brothers Funeral Ser, P.A. 1300 Eutaw Place, Baltimore, Md. 21217		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Alcohol and Narcotic Intoxication Due to (or as a consequence of): a. b. c. d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	
23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <input type="checkbox"/> Unknown		23d. Date of delivery Month Day Year	
24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Pending investigation <input checked="" type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year) found 1/30/04	
28b. Time of Injury found 5:05 p		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred unknown	
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) found inside a bus		28f. Location (Street and Number or Rural Route Number, City or Town, State) Cedonia Road and Hazelwood		28g. Baltimore, MD	
29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier Theodore M. King		29c. License number O.C.M.E.	
29d. Date signed (Month, Day, Year) January 31, 2004		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) THEODORE M. King		31. Date filed (Month, Day, Year) FEB 10 2004	
32. Registrar's Signature [Signature]		33. Date of Death January 30, 2004		34. Time of Death 17:52P^M	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

1- For
State
Registrar

2004 03723

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

HILDA Mitchell

2. Date of Death

02 05 2004

3. Time of Death

10:06P M

4a. Facility Name (If not institution, give street and number)

Bon Secours Hospital

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

N/A

Funeral
Director

5. Social Security Number

216-20-0632

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

84

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

3-27-19

9. Birthplace (State or Foreign Country)

Baltimore, Md.

Usual Residence of Decedent

10a. State

Md.

10b. County

N/A

10c. City, Town or Location

Baltimore

10d. Inside City Limits

☒ Yes ☐ No

10e. Street and Number

2513 Calverton Height Ave.

10f. Zip Code

21216

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Sales Clerk

16b. Kind of Business/Industry

Hetch Co.

17. Father's Name (First, Middle, Last)

Albert Brown

18. Mother's Name (First, Middle, Maiden Surname)

Annie Brown

19a. Informant's Name/Relationship (Type, Print)

Faye Tucker (D)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2513 Calverton Height Ave, Balto, Md. 21216

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Cheltenham VA.Cem. 2-17-04

Date

20c. Location - City or Town, State

Cheltenham, Md.

21. Signature of Funeral Service Licensee

Lloyd M. Estep

22. Name and Address of Facility

Estep Brothers Funeral Ser, P.A.

1300 Eutaw Place, Baltimore, Md. 21217

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. CARDIOPULMONARY ARREST

Due to (or as a consequence of):

b. Metastatic Lung Cancer

Due to (or as a consequence of):

c. Breast Cancer

Due to (or as a consequence of):

d.

Approximate Interval Between Onset and Death

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☒ No9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death4 ☐ Pregnant at time of death9 ☐ Unknown3 ☐ Ectopic pregnancy5 ☐ Other (specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient3 ☒ OOA

26. Place of Death (Check only one)

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☒ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

J.A. Hamilton, MD, Staff physician

29c. License number

D08291

29d. Date signed (Month, Day, Year)

02-05-2004

30. Name and address of person who completed cause of death (from 23a) (Type, Print)

FA HAMILTON, M.D., 2000 W. Baltimore St, BALTIMORE, Md, 21223

31. Date filed (Month, Day, Year)

FEB 10 2004

32. Registrar's Signature

Benjamin B. Sparks

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be examined within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

State
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2004 03724

1- For
State
RegistrarPhysician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

James Franklin Miles Sr.

2. Date of Death

February 4 2004

3. Time of Death

5:35 P M

Funeral
Director

4a. Facility Name (If not institution, give street and number)

North Arundel Hospital

4b. City, Town, or Location of Death

Glen Burnie

4c. County of Death

Anne Arundel

5. Social Security Number

219-22-6938

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

75 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Sep. 10, 1928

9. Birthplace (State or Foreign Country)

MD

Usual Residence of Decedent

10a. State

MD

10b. County

Anne Arundel

10c. City, Town or Location

Glen Burnie

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

1618 Furnace Road

10f. Zip Code

21060

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: white

15. Decedent's Education
(Specify only highest grade completed)Elementary/Secondary (0-12)
8

College (1-4or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Vending Machine Operator

16b. Kind of Business/Industry

Gabe Chamy

17. Father's Name (First, Middle, Last)

Milton Miles

18. Mother's Name (First, Middle, Maiden Surname)

Adeline Warner

19a. Informant's Name/Relationship (Type, Print)

Mrs. Dorothy Miles - wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1618 Furnace Road, Glen Burnie, Maryland 21060

20a. Method of Disposition

1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☒ Other (Specify)

mausoleum

20b. Place of Disposition (Name of
cemetery, crematory or other place)

Cedar Hill Cemetery

Date

Feb 9, 2004

20c. Location - City or Town, State

Brooklyn, MD

21. Signature of Funeral Service Licensee

[Signature]

22. Name and Address of Facility

Singleton Funeral Home P.A.
1 Second Avenue S.W., Glen Burnie, MD 2106123a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

a. Congestive Heart Failure

Due to (or as a consequence of):

b. Coronary atherosclerosis

Due to (or as a consequence of):

c. Coronary artery disease

Due to (or as a consequence of):

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) LastApproximate
Interval Between
Onset and Death

1 Day

37 Years

6 Years

IF FEMALE:

23b. Was decedent pregnant
in the past 12 months?1 ☐ Yes 2 ☐ No
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown3 ☐ Ectopic pregnancy
5 ☐ Other (specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an
autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings available
prior to completion of cause of
death?1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient2 ☒ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending
investigation
2 ☐ Accident 6 ☐ Could not be
determined
3 ☐ Suicide
4 ☐ Homicide

28a. Date of Injury

(Month, Day Year)

28b. Time of
Injury

M

28c. Injury at
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
and manner stated.

29b. Signature and title of certifier

[Signature] ATTENDING DOCTOR
P.V. CYRIAC-MO

29c. License number

021684

29d. Date signed (Month, Day, Year)

02-05-2004

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

P.V. CYRIAC-MO 8021 RITCHIE AVE, PASADENA, MD 21122

State
Registrar

31. Date filed (Month, Day, Year)

FEB 10 2004

32. Registrar's Signature

[Signature]

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2004 03725

Certificate of Death

Reg. No.

1- For
State
RegistrarPhysician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Elizabeth Rogers Mullan

2. Date of Death

February 6, 2004

3. Time of Death

7:30P M

4a. Facility Name (If not institution, give street and number)

Blakehurst

4b. City, Town, or Location of Death

Towson

4c. County of Death

Baltimore

5. Social Security Number

216-03-1779

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

89

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

October 16, 1914

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Baltimore

10c. City, Town or Location

Towson

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

1055 West Joppa Road

10f. Zip Code

21204

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: White

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

Clifton

Rogers

18. Mother's Name (First, Middle, Maiden Surname)

Agnes

Price

19a. Informant's Name/Relationship (Type, Print)

Marylou Fineran

DTR

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

614 Manor Drive Salisbury Maryland 21801

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Druid Ridge Cemetery

Date

2/9/04

20c. Location - City or Town, State

Pikesville, Maryland

21. Signature of Funeral Service Licensee

Annex Stephen Kenakis

22. Name and Address of Facility

Mitchell-Wiedefeld Funeral Home, Inc.
6500 York Rd. Baltimore, MD 2121223a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

Cerebrovascular Accident

Approximate
Interval Between
Onset and Death

3 weeks

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

a. Due to (or as a consequence of):

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

IF FEMALE:

23b. Was decedent pregnant

in the past 12 months?
1 ☐ Yes 2 ☒ No
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown3 ☐ Ectopic pregnancy
5 ☐ Other (specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Hypertension

Generalized Atherosclerotic Vascular Disease

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an
autopsy
performed?
1 ☐ Yes 2 ☒ No24b. Were autopsy findings available
prior to completion of cause of
death?
1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ ODA

Other:

4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation
6 ☐ Could not be determined

28a. Date of Injury

(Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
and manner stated.

29b. Signature and title of certifier

Iredell W. Iglehart III MD

29c. License number

D33400

29d. Date signed (Month, Day, Year)

02/07/2004

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

IREDELL W. IGLEHART, III, MD 6301 N CHARLES STREET BALTIMORE MD 21212

31. Date filed (Month, Day, Year)

FEB 10 2004

32. Registrar's Signature

Annex Stephen Kenakis

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.Physician
/Medical
Examiner

To Be Completed by Funeral Director

Medical Certification; To Be Completed by Physician/Medical Examiner

State
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

AMEND ITEM #18&19a PER INF G828

2/10/04 Jh

Certificate of Death

Reg. No.

2004 03726

Physician / Medical Examiner	1. Decedent's Name (First, Middle, Last) LORETTA RUTH MILLER			2. Date of Death Month February Day 06 Year 2004		3. Time of Death 12:05A M	
	4a. Facility Name (If not institution, give street and number) Good Samaritan Hospital			4b. City, Town, or Location of Death Baltimore		4c. County of Death NA	
Funeral Director	5. Social Security Number 234-10-8373	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 86 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) AUG. 27, 1917	9. Birthplace (State or Foreign Country) MD
	Usual Residence of Decedent						
To Be Completed by Funeral Director	10a. State MD	10b. County N/A	10c. City, Town or Location BALTIMORE			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
	10e. Street and Number 7111 PARK HEIGHTS AVENUE, APT. 212			10f. Zip Code 21215		10g. Citizen of What Country? U.S.A.	
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: WHITE
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 1+ College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) HOMEMAKER		16b. Kind of Business/Industry OWN HOME		
	17. Father's Name (First, Middle, Last) LOUIS J. FINK			18. Mother's Name (First, Middle, Maiden Surname) ANNA WASSERKRUG WASSERKING			
To Be Completed by Physician/Medical Examiner	19a. Informant's Name (Relationship, Type, Print) MR. FREDERICK MILLER / SON FRED MILLER / SON			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3 HALCYON COURT - BALTIMORE, MD 21208			
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) CHIZUK AMUNO ARLINGTON		Date 2/8/2004		20c. Location - City or Town, State BALTIMORE, MD
	21. Signature of Funeral Service Licensee Edward C. Reed			22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Sepsis Due to (or as a consequence of): b. Pneumonia Due to (or as a consequence of): c. Clostridium Difficile Due to (or as a consequence of): d.						
	Approximate Interval Between Onset and Death DAYS DAYS DAYS						
Physician / Medical Examiner	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <input type="checkbox"/> Unknown		23d. Date of delivery Month Day Year		
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Acute Renal Failure						
	23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Probably <input type="checkbox"/> Unknown						
	24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No						
Medical Certification: To Be Completed by Physician/Medical Examiner	26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined			
	28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)						
	28f. Location (Street and Number or Rural Route Number, City or Town, State)						
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.						
29b. Signature and title of certifier W. A. [Signature] M.D.		29c. License number D0058457		29d. Date signed (Month, Day, Year) February 07, 2004			
State Registrar	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) NANA CEASAR 5601 Loch Raven Blvd. Baltimore, MD 21239						
	31. Date filed (Month, Day, Year) FEB 10 2004		32. Registrar's Signature [Signature]				

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2004 03727

1- For State Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Imogene M. Morlock			2. Date of Death Month Day Year February 5 2004		3. Time of Death 10:15A.M.	
	4a. Facility Name (If not institution, give street and number) North Arundel Hospital			4b. City, Town, or Location of Death Glen Burnie		4c. County of Death Anne Arundel	
Funeral Director	5. Social Security Number 235-36-5298		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 77 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) June 23 1926
	9. Birthplace (State or Foreign Country) WV						
To Be Completed by Funeral Director	Usual Residence of Decedent						
	10a. State Maryland		10b. County Anne Arundel		10c. City, Town or Location Pasadena		10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
	10e. Street and Number 7721 Shirley Avenue			10f. Zip Code 21122		10g. Citizen of What Country? USA	
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 8 College (1-4 or 5+) 8			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker		16b. Kind of Business/Industry Household	
	17. Father's Name (First, Middle, Last) Cecil Perkins			18. Mother's Name (First, Middle, Maiden Surname) Nina America			
	19a. Informant's Name/Relationship (Type, Print) Carol Morlock (daughter)			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7721 Shirley Avenue,, Pasadena, MD 21122			
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) Meadowridge Cemetery		20c. Location - City or Town, State Elkridge, Maryland	
	21. Signature of Funeral Service Licensed [Signature]			22. Name and Address of Facility Stallings Funeral Home, P.A. 3111 Mountain RD., Pasadena, MD 21122			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Pneumonia Due to (or as a consequence of): b. Lung Cancer Due to (or as a consequence of): c. Colon Cancer Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last						
23b. IF FEMALE: Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 9 <input type="checkbox"/> Unknown							
23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) 9 <input type="checkbox"/> Unknown							
23d. Date of delivery Month Day Year							
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input checked="" type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown							
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No							
24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No							
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No							
26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)							
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined							
28a. Date of Injury (Month, Day, Year)							
28b. Time of Injury M							
28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No							
28d. Describe how injury occurred							
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)							
28f. Location (Street and Number or Rural Route Number, City or Town, State)							
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.							
29b. Signature and title of certifier [Signature] M.D.							
29c. License number D43977							
29d. Date signed (Month, Day, Year) February 5 2004							
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Angela Chestnut, 301 Hospital Drive, Glen Burnie, MD 21061.							
31. Date filed (Month, Day, Year) FEB 10 2004							
32. Registrar's Signature [Signature]							

Imogene morlock
Baltimore, Maryland 21215-0036
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

1- For
State
Registrar

2004 03728

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Anna M. Ochs				2. Date of Death Month February Day 2 Year 2004				3. Time of Death 4:55 P. M	
	4a. Facility Name (If not institution, give street and number) Mariner Health of Glen Burnie				4b. City, Town, or Location of Death Glen Burnie				4c. County of Death Anne Arundel	
Funeral Director	5. Social Security Number 213 10 2543		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 86 Yrs.		8. Date of Birth (Month, Day, Year) March 22, 1917		9. Birthplace (State or Foreign Country) Maryland	
	Usual Residence of Decedent									
10a. State Maryland		10b. County Anne Arundel		10c. City, Town or Location Baltimore				10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
10e. Street and Number 107 Cedar Hill Road				10f. Zip Code 21225		10g. Citizen of What Country? U.S.				
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 9th College (1-4 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Underwriter			16b. Kind of Business/Industry Insurance Company			
17. Father's Name (First, Middle, Last) (not available) Deems				18. Mother's Name (First, Middle, Maiden Surname) (not available) Soule						
19a. Informant's Name/Relationship (Type, Print) Ann Canova / Daughter				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 107 Cedar Hill Road Baltimore, Maryland 21225						
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Meadowridge Mem. Park		Date 2/6/2004		20c. Location - City or Town, State Elkridge, Maryland		
21. Signature of Funeral Service Licensee <i>Sharon Leggett</i>				22. Name and Address of Facility Gonce Funeral Service, P.A. 4001 Ritchie Highway Baltimore, Maryland 21225						
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Coronary Heart Failure										
23b. Part II. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Acute Renal Failure										
23c. Part III. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Diabetes Mellitus II										
23d. Part IV. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Post Coronary Artery Bypass										
23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 9 <input type="checkbox"/> Unknown				23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify)				23d. Date of delivery Month Day Year		
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Chronic Bronchitis								23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown		
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)						
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined				28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28d. Describe how injury occurred						
28e. Location (Street and Number or Rural Route Number, City or Town, State)				28f. Location (Street and Number or Rural Route Number, City or Town, State)						
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. Signature and title of certifier <i>Carlos M. Patalinghug</i> CARLOS M. PATALINGHUG CRMD				29c. License number D18426		
29d. Date signed (Month, Day, Year) February 3, 2004										
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DR. CARLOS PATALINGHUG 3721 Potee ST. Balto, MD 21225										
31. Date filed (Month, Day, Year) FEB 10 2004				32. Registrar's Signature <i>Ann B. Smith</i>						

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, this Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2004 03729

1- For
State
RegistrarPhysician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Evelyn

Panek

2. Date of Death
Month Day Year
February 7, 20043. Time of Death
2:10 P M

4a. Facility Name (If not institution, give street and number)

6801 Fait Avenue

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

N/A

Funeral
Director

5. Social Security Number

212-30-1771

6. Sex
1 ☐ M 2 ☒ F7. Age (In yrs. last birthday)
70 Yrs.8. Date of Birth
(Month, Day, Year)
August 30, 19339. Birthplace (State or Foreign
Country)
MD.

Usual Residence of Decedent

10a. State

MD

10b. County

N/A

10c. City, Town or Location

Baltimore

10d. Inside City Limits

☒ Yes 2 ☐ No

10e. Street and Number

6801 Fait Avenue

10f. Zip Code

21224

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☐ Widowed 4 ☒ Divorced12. Was Decedent Ever in U.S.
Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: White

15. Decedent's Education
(Specify only highest grade completed)Elementary/Secondary (0-12)
12 years

College (1-4or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Director

16b. Kind of Business/Industry

Food Service

17. Father's Name (First, Middle, Last)

Casimir Sokal

18. Mother's Name (First, Middle, Maiden Surname)

Michalina Wionzcek

19a. Informant's Name/Relationship (Type, Print)

Joanne Heddingher Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

6801 Fait Avenue, Baltimore, Md. 21224

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Sacred Heart Of Mary Cem.

Date
February
11, 2004

20c. Location - City or Town, State

Dundalk, MD.

21. Signature of Funeral Service Licensee

Anthony Connelly

22. Name and Address of Facility

Connelly Funeral Home Of Dundalk, P.A.
7110 Sollers Point Road, Dundalk, MD. 2122223a. Part I: Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

a. Pulmonary Hypertension

Due to (or as a consequence of):

b. Scleroderma

Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate
Interval Between
Onset and Death
4 years
10 years

IF FEMALE:

23b. Was decedent pregnant
in the past 12 months?
1 ☐ Yes 2 ☒ No
9 ☐ Unknown23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown3 ☐ Ectopic pregnancy
5 ☐ Other (specify)23d. Date of delivery
Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Rheumatoid arthritis

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an
autopsy performed?
1 ☐ Yes 2 ☒ No24b. Were autopsy findings available
prior to completion of cause of
death?
1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?
1 ☐ Yes 2 ☒ NoHospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural 5 ☐ Pending
2 ☐ Accident investigation
3 ☐ Suicide 6 ☐ Could not be
4 ☐ Homicide determined28a. Date of Injury
(Month, Day Year)28b. Time of
Injury28c. Injury at
Work?
1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
and manner stated.

29b. Signature and title of certifier

Michael Harper, MD

29c. License number

D43732

29d. Date signed (Month, Day, Year)

February 9, 2004

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Michael Harper, MD 5505 Hopkins Bayview Circle, Baltimore, MD 21224

31. Date filed (Month, Day, Year)

FEB 10 2004

32. Registrar's Signature

[Signature]

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.Physician
/Medical
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene
Certificate of Death

Reg. No.

2004 03730

1- For
State
Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Catherine Teresa Preisinger				2. Date of Death Month February Day 5 Year 2004		3. Time of Death 10:00A M	
	4a. Facility Name (If not institution, give street and number) Gilchrist Center				4b. City, Town, or Location of Death Towson		4c. County of Death Baltimore	
Funeral Director	5. Social Security Number 219-30-2692		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 69 Yrs.		8. Date of Birth (Month, Day, Year) Sept 27, 1934	
	9. Birthplace (State or Foreign Country) Maryland		10a. State Maryland		10b. County Baltimore		10c. City, Town or Location White Hall	
To Be Completed by Funeral Director	10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		10e. Street and Number 17609 Troyer Road		10f. Zip Code 21161		10g. Citizen of What Country? USA	
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4or 5+) n/a		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker		16b. Kind of Business/Industry Own Home			
	17. Father's Name (First, Middle, Last) Salvatore Pistorio				18. Mother's Name (First, Middle, Maiden Surname) Antonette Gelsomino			
	19a. Informant's Name/Relationship (Type, Print) John T. Preisinger, Sr./Husband				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 17609 Troyer Road, White Hall, Maryland 21161			
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Dulaney Valley Me. Grdns.		20c. Location - City or Town, State Timonium, Maryland		20d. Date 2/9/04	
	21. Signature of Funeral Service Licensee Bryan W. Clary		22. Name and Address of Facility Lemmon Funeral Home of Dulaney Valley Inc. 10 W. Padonia Road, Timonium, MD 21093					
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Breast Cancer							
	23b. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
	23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify)							
23d. Date of delivery Month Day Year								
23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown								
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No								
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								
26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) Hospice								
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		
28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.								
29b. Signature and title of certifier W. A. Riley MD		29c. License number D25205		29d. Date signed (Month, Day, Year) February 5, 2004				
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) W. A. Riley G BMC 6701 N. Charles St, Balto md 21204								
31. Date filed (Month, Day, Year) FEB 10 2004		32. Registrar's Signature [Signature]						

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

1- For
State
Registrar

2004 03731

Physician
/Medical
ExaminerFuneral
Director

1. Decedent's Name (First, Middle, Last)

ANNA

ROSE

PHILLIPS

2. Date of Death

Month Day Year
FEBRUARY 4, 2004

3. Time of Death

3:20 P M

4a. Facility Name (If not institution, give street and number)

KNOLLWOOD MANOR NURSING HOME

4b. City, Town, or Location of Death

MILLERSVILLE

4c. County of Death

ANNE ARUNDEL

5. Social Security Number

263-24-7572

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

80 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
10/5/1923

9. Birthplace (State or Foreign Country)

FLORIDA

Usual Residence of Decedent

10a. State

MD

10b. County

ANNE ARUNDEL

10c. City, Town or Location

GLEN BURNIE

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

533 CRESTPARK DRIVE

10f. Zip Code

21061

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: WHITE

15. Decedent's Education
(Specify only highest grade completed)Elementary/Secondary (0-12)
12

College (1-4or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

ELECTRICAL INSPECTOR

16b. Kind of Business/Industry

MARTIN AIRCRAFT

17. Father's Name (First, Middle, Last)

UNKNOWN

18. Mother's Name (First, Middle, Maiden Surname)

UNKNOWN

19a. Informant's Name/Relationship (Type, Print)

ROBERT EARL PHILLIPS, JR. - SON

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

533 CRESTPARK DRIVE, GLEN BURNIE, MD 21061

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

LOUDON PARK CEMETERY

Date

2/9/2004

20c. Location - City or Town, State

BLATIMORE, MD

21. Signature of Funeral Service Licensee

KELLY GREGORY FINK #M01148

22. Name and Address of Facility

FINK FUNERAL HOME, PA

426 CRAIN HWY., S, GLEN BURNIE, MD 21061

23a. Part I. Enter the disease or diseases that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

a. PNEUMONIA

Due to (or as a consequence of):

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate
Interval Between
Onset and Death
1 WEEK

IF FEMALE:

23b. Was decedent pregnant
in the past 6 months?1 ☐ Yes 2 ☒ No
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy
4 ☐ Pregnant at time of death 5 ☐ Other (specify)
9 ☐ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an
autopsy
performed?
1 ☐ Yes 2 ☒ No24b. Were autopsy findings available
prior to completion of cause of
death?
1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation
6 ☐ Could not be determined28a. Date of Injury
(Month, Day Year)28b. Time of
Injury28c. Injury at
Work?
1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)29b. Signature and title of certifier
B. C. Wallace MD
29c. License number
123136
29d. Date signed (Month, Day, Year)
FEBRUARY 7, 2004

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

BRIAN C. WALLACE, MD, 9005 KILBRIDE RD, NOTTINGHAM, MD 21236

31. Date filed (Month, Day, Year)

FEB 10 2004

32. Registrar's Signature

B. C. Wallace

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or item 23e or 24a-1 show
any injury or other traumatic event, the Medical Examiner must be notified at
once.Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit
document.

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2004 03732

1- For State Registrar

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Physician /Medical Examiner

Funeral Director

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

1. Decedent's Name (First, Middle, Last) John Engel Pfeffer				2. Date of Death Month February Day 6 Year 2004		3. Time of Death 09:30 A M	
4a. Facility Name (If not institution, give street and number) 201 Buckingham Drive				4b. City, Town, or Location of Death Glen Burnie		4c. County of Death Anne Arundel	
5. Social Security Number 218-09-3839		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 83 Yrs.		8. Date of Birth (Month, Day, Year) Dec 20, 1920	
9. Birthplace (State or Foreign Country) MD		10a. State MD		10b. County Anne Arundel		10c. City, Town or Location Glen Burnie	
10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		10e. Street and Number 201 Buckingham Drive		10f. Zip Code 21061		10g. Citizen of What Country? USA	
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: 39-45		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 9 College (1-4or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Bus Driver		16b. Kind of Business/Industry MTA		17. Father's Name (First, Middle, Last) Richard J. Pfeffer	
18. Mother's Name (First, Middle, Maiden Surname) Mary Engel		19a. Informant's Name/Relationship (Type, Print) Mrs. Helen Pfeffer / Wife		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 201 Buckingham Drive Glen Burnie, MD 21061		20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)	
20b. Place of Disposition (Name of cemetery, crematory or other place) Maryland Veterans		20c. Date Feb 10 2004		20d. Location - City or Town, State Crownsville, MD		21. Signature of Funeral Service Licensee Donna Williams	
22. Name and Address of Facility Singleton Funeral Home, P.A. 11 Second Avenue SW Glen Burnie, MD 21061		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Colon Cancer metastatic		23b. Immediate Cause (Final disease or condition resulting in death) COPD with fibrosis		23c. Underlying Cause (Disease or injury that initiated events resulting in death) Last Anemia	
23d. Part II. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Anemia		23e. Due to (or as a consequence of):		23f. Due to (or as a consequence of):		23g. Due to (or as a consequence of):	
23h. Due to (or as a consequence of):		23i. Due to (or as a consequence of):		23j. Due to (or as a consequence of):		23k. Due to (or as a consequence of):	
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Unknown		23d. Ectopic pregnancy <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Other (specify)		23e. Date of delivery Month Day Year	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				23f. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown			
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)		29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.	
29b. Signature and title of certifier Chimene Liburd		29c. License number D54020		29d. Date signed (Month, Day, Year) February 9 2004		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 300 Hospital Drive Suite 215 Glen Burnie MD 21061	
31. Date filed (Month, Day, Year) FEB 10 2004		32. Registrar's Signature Donna Williams					

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2004 03733

1- For State Registrar

Physician /Medical Examiner

Funeral Director

1. Decedent's Name (First, Middle, Last) FRANCIS XAVIER POWERS				2. Date of Death Month Day Year February 5, 2004				3. Time of Death 9:20A M	
4a. Facility Name (If not institution, give street and number) Genesis Loch Raven				4b. City, Town, or Location of Death Parkville				4c. County of Death Baltimore	
5. Social Security Number 219-22-1454		6. Sex XX ^M 2 ^F	7. Age (In yrs. last birthday) 76 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) September 21, 1927		9. Birthplace (State or Foreign Country) Maryland	
Usual Residence of Decedent									
10a. State Maryland		10b. County Baltimore		10c. City, Town or Location Parkville				10d. Inside City Limits 1 ^{Yes} 2 ^{No} XX	
10e. Street and Number 8720 Emge Road				10f. Zip Code 21234		10g. Citizen of What Country? USA			
11. Marital Status 1 ^{Never Married} 2 ^{Married} XX ^{Widowed} 4 ^{Divorced}		12. Was Decedent Ever in U.S. Armed Forces? XX ^{Yes} 2 ^{No} WWII If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ^{Yes} XX ^{No} Specify:			14. Race - American Indian, Black, White, etc. Specify: White		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 2				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Manager			16b. Kind of Business/Industry Hotel		
17. Father's Name (First, Middle, Last) Joseph Francis Powers Sr				18. Mother's Name (First, Middle, Maiden Surname) Helena Martin					
19a. Informant's Name/Relationship (Type, Print) Joseph F Powers Jr Brother				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 714 Shelly Road Towson, Maryland 21286					
20a. Method of Disposition 1 ^{Burial} 2 ^{Cremation} 3 ^{Removal from State} 4 ^{Donation} 5 ^{Other (Specify)}				20b. Place of Disposition (Name of cemetery, crematory or other place) Garrison Forest VA		Date 2/10/04		20c. Location - City or Town, State Owings Mills, Maryland	
21. Signature of Funeral Service Licensee <i>Bennis Stephen Kenaka</i>				22. Name and Address of Facility Mitchell-Wiedefeld Funeral Home Inc. 6500 York Road Baltimore, Maryland 21212					

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. <i>Isolated Atrial Fibrillation</i> Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, starting with the immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last				Approximate Interval Between Onset and Death	
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ^{Yes} 2 ^{No} 9 ^{Unknown}		23c. If yes, outcome of pregnancy 1 ^{Live birth} 2 ^{Fetal death} 3 ^{Ectopic pregnancy} 4 ^{Pregnant at time of death} 5 ^{Other (specify)} 9 ^{Unknown}		23d. Date of delivery Month Day Year	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Small cell CA</i>				23e. Did tobacco use contribute to the cause of death? 1 ^{Yes} 2 ^{No} 3 ^{Probably} 4 ^{Unknown} XX	
24a. Was an autopsy performed? 1 ^{Yes} 2 ^{No} XX		24b. Were autopsy findings available prior to completion of cause of death? 1 ^{Yes} 2 ^{No} XX			
25. Was case referred to medical examiner? 1 ^{Yes} 2 ^{No} XX		26. Place of Death (Check only one) Hospital: 1 ^{Inpatient} 2 ^{ER/Outpatient} 3 ^{DOA} Other: 4 ^{Nursing Home} 5 ^{Residence} 6 ^{Other (Specify)}			
27. Manner of Death 1 ^{Natural} 2 ^{Accident} 3 ^{Suicide} 4 ^{Homicide} 5 ^{Pending investigation} 6 ^{Could not be determined}		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M 1 ^{Yes} 2 ^{No}	
28c. Injury at Work? 1 ^{Yes} 2 ^{No}		28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	
28f. Location (Street and Number or Rural Route Number, City or Town, State)		29a. Certifier (Check only one) 1 ^{Certifying Physician} 2 ^{Medical Examiner} To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.			
29b. Signature and title of certifier <i>Martha Raymundo, MD</i>		29c. License number D54518		29d. Date signed (Month, Day, Year) 2-6-2004	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MARATHA RAYMONDO, MD 5601 Loch Raven Blvd Baltimore MD 21237					
31. Date filed (Month, Day, Year) FEB 10 2004		32. Registrar's Signature <i>John H. Apple</i>			

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2004 03734

1- For State Registrar

Physician / Medical Examiner	1. Decedent's Name (First, Middle, Last) John Franklin Pitcock, Sr.				2. Date of Death Month Day Year 02 05 2004		3. Time of Death 7:20 p.m.	
	4a. Facility Name (If not institution, give street and number) Franklin Square Hospital				4b. City, Town, or Location of Death Rosedale		4c. County of Death Baltimore	
Funeral Director	5. Social Security Number 213-18-6992	6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F	7. Age (In yrs. last birthday) 83 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) April 15, 1920		9. Birthplace (State or Foreign Country) Maryland
	Usual Residence of Decedent							
10a. State Maryland		10b. County Baltimore		10c. City, Town or Location Parkville			10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
10e. Street and Number 8820 Walther Blvd., Apt. 3104				10f. Zip Code 21234		10g. Citizen of What Country? U.S.A.		
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates: WW II		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 2				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Salesman		16b. Kind of Business/Industry Trucking		
17. Father's Name (First, Middle, Last) Charles E. Pitcock, Sr.				18. Mother's Name (First, Middle, Maiden Surname) Margaret Powell				
19a. Informant's Name/Relationship (Type, Print) Ms. Barbara Ann Pitcock (dghtr)				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4105 Pinedale Drive, Baltimore, MD 21236				
20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Bayview Crematory		Date 2/10/2004		20c. Location - City or Town, State Baltimore, Maryland		
21. Signature of Funeral Service Licensee				22. Name and Address of Facility Schimunek Funeral Homes 9705 Belair Rd., Baltimore, MD 21236				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. acute cerebral infarction Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last								Approximate Interval Between Onset and Death
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 4 <input type="checkbox"/> Pregnant at time of death 9 <input type="checkbox"/> Unknown			3 <input type="checkbox"/> Ectopic pregnancy 5 <input type="checkbox"/> Other (specify)		23d. Date of delivery Month Day Year	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown		
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No						24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)						
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)						
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.								
29b. Signature and title of certifier Dr. Jack Ko				29c. License number 755885		29d. Date signed (Month, Day, Year) 2/5/04		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr. Jack Ko 9000 Franklin Square Drive, Baltimore, Md. 21237								
31. Date filed (Month, Day, Year) FEB 10 2004				32. Registrar's Signature [Signature]				

John Pitcock Sr.
Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician / Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2004 03735

1- For
State
RegistrarPhysician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Kathleen Robinson

2. Date of Death

Month Day Year
Feb. 8 2004

3. Time of Death

5:50 AM

4a. Facility Name (If not institution, give street and number)

Riverview Nursing Center

4b. City, Town, or Location of Death

Essex

4c. County of Death

Baltimore

5. Social Security Number

216-54-3507

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

52 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
Nov. 2, 1951

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

MD

10b. County

Baltimore

10c. City, Town or Location

Essex

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

1121 Tace Drive

10f. Zip Code

21221

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give
Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No.

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.
Specify: White15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

12th

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Child Care

16b. Kind of Business/Industry

Day Care

17. Father's Name (First, Middle, Last)

James Marchant

18. Mother's Name (First, Middle, Maiden Surname)

Helen Asch

19a. Informant's Name/Relationship (Type, Print)

Helen Marchant/mother

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

317 Leeanne Road Baltimore MD 21221

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Bayview Crematory

Date

2/10/04

20c. Location - City or Town, State

Baltimore MD

21. Signature of Funeral Service Licensee

R. Terry Connelly

22. Name and Address of Facility

ConnellyFuneralHomeofEssex
300 Mace Ave. Baltimore MD 2122123a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

a. End Stage Liver Disease

Due to (or as a consequence of):

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate
Interval Between
Onset and Death

IF FEMALE:

23b. Was decedent pregnant
in the past 12 months?
1 ☐ Yes 2 ☐ No
3 ☒ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death
3 ☐ Ectopic pregnancy
4 ☐ Pregnant at time of death
5 ☐ Other (Specify)
9 ☐ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an
autopsy
performed?
1 ☐ Yes 2 ☒ No24b. Were autopsy findings available
prior to completion of cause of
death?
1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?
1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending
investigation
2 ☐ Accident 6 ☐ Could not be
determined
3 ☐ Suicide 4 ☐ Homicide28a. Date of Injury
(Month, Day Year)28b. Time of
Injury

M

28c. Injury at
Work?
1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
and manner stated.

29b. Signature and title of certifier

J. M. Z.

29c. License number

D43725

29d. Date signed (Month, Day, Year)

2/9/04

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

TARIQ MAHMOOD 201-109 Back River Neck Rd Baltimore MD 21221

31. Date filed (Month, Day, Year)

32. Registrar's Signature

FEB 10 2004

J. M. Z.

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show
any injury or other traumatic event, the Medical Examiner must be notified at
once.To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar AMEND ITEM #20a c PER FH G828 2/13/04

Reg. No.

2004 03736

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Earl Robinson Sr.

2. Date of Death

Month Day Year
FEB. 6, 2004

3. Time of Death

11:30 AM

4a. Facility Name (If not institution, give street and number)

925 NORTH BROADWAY APT. 409

4b. City, Town, or Location of Death

BALTIMORE CITY

4c. County of Death

N/A

Funeral
Director

5. Social Security Number

213-34-7808

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

65 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

Sept. 3, 1938

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

N/A

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

925 N. Broadway St. Apt. 409

10f. Zip Code

21205

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☒ Yes 2 ☐ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4or 5+)

0

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Porter

16b. Kind of Business/Industry

Ice House

17. Father's Name (First, Middle, Last)

Harvey Robinson

18. Mother's Name (First, Middle, Maiden Sumame)

Martha Banks Robinson

19a. Informant's Name/Relationship (Type, Print)

Ms. Sharon Robinson

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

824 N. Streep St. Balto. Md. 21205

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

MT. CARMEL

Date

2/13/2004

20c. Location - City or Town, State

DUNDALK, MD

21. Signature of Funeral Service Licensee

Joseph L. Russ

22. Name and Address of Facility

Joseph L. Russ Funeral Home
2222 W. North Ave. Balto. Md. 21216

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Arteriosclerotic Cardiovascular Disease

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☐ No9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death4 ☐ Pregnant at time of death9 ☐ Unknown3 ☐ Ectopic pregnancy5 ☐ Other (Specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☒ Yes 2 ☐ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence6 ☒ Other (Specify) AT SCENE

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation2 ☐ Accident 6 ☐ Could not be determined3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Tasha Z Greenberg MD

29c. License number

O.C.M.E

29d. Date signed (Month, Day, Year)

FEB. 6, 2004

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Tasha Z Greenberg M.D.

111 Penn Street, Baltimore, Maryland 21201

31. Date filed (Month, Day, Year)

FEB 10 2004

32. Registrar's Signature

B. Sparks

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2004 03737

1- For
State
Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) William Everett Ridgley				2. Date of Death Month Day Year February 5 2004		3. Time of Death 11:20 PM	
	4a. Facility Name (If not institution, give street and number) St. Agnes Health care				4b. City, Town, or Location of Death Baltimore		4c. County of Death	
Funeral Director	5. Social Security Number 212-10-5492		6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		7. Age (In yrs. last birthday) 86 Yrs.		8. Date of Birth (Month, Day, Year) Oct 25, 1917	
	9. Birthplace (State or Foreign Country) Maryland		10a. State Maryland		10b. County Baltimore		10c. City, Town or Location Baltimore	
To Be Completed by Funeral Director	10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		10e. Street and Number 927 St. Agnes Lane		10f. Zip Code 21207		10g. Citizen of What Country? U.S.A.	
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No 1943- If Yes, Give Year or Dates: 1945		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White	
To Be Completed by Physician/Medical Examiner	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 8 College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Plumber		16b. Kind of Business/Industry Plumbing		17. Father's Name (First, Middle, Last) George W. Ridgley	
	18. Mother's Name (First, Middle, Maiden Surname) Emma Smallwood		19a. Informant's Name/Relationship (Type, Print) Elizabeth D. Ridgley (Wife)		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 927 St. Agnes Lane Baltimore, Maryland 21207		20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)	
To Be Completed by Physician/Medical Examiner	20b. Place of Disposition (Name of cemetery, crematory or other place) Woodlawn Cemetery		20c. Date 2-11-2004		20d. Location - City or Town, State Woodlawn, Maryland		21. Signature of Funeral Service Licensee 	
	22. Name and Address of Facility Witzke Funeral Home of Catonsville, Inc. 1630 Edmondson Avenue Catonsville, MD 21228		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. ASCVD Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Approximate Interval Between Onset and Death Years		23b. If FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown 23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) 9 <input type="checkbox"/> Unknown		23d. Date of delivery Month Day Year	
To Be Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Congestive Heart Failure Renal Failure		24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
	26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year) 28b. Time of Injury M 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28c. Injury at Work? 28d. Describe how injury occurred	
To Be Completed by Physician/Medical Examiner	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)		29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier 	
	29c. License number D0053312		29d. Date signed (Month, Day, Year) February 6, 2004		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Michelle Henggeler 900 caton Avenue, Baltimore, MD 21229		31. Date filed (Month, Day, Year) FEB 10 2004	
State Registrar	32. Registrar's Signature 		33. Date of Death February 5, 2004		34. Time of Death 11:20 PM		35. County of Death Baltimore	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

1- For
State
Registrar

2004 03738

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) DORIS JEAN RING				2. Date of Death Month Day Year FEBRUARY 4, 2004		3. Time of Death 8:00A M	
	4a. Facility Name (If not institution, give street and number) 543 NOLFIELD DRIVE				4b. City, Town, or Location of Death GLEN BURNIE		4c. County of Death ANNE ARUNDEL	
Funeral Director	5. Social Security Number 579-34-4769	6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 73 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) 4/25/1930	9. Birthplace (State or Foreign Country) OHIO	
	Usual Residence of Decedent							
To Be Completed by Funeral Director	10a. State MD	10b. County ANNE ARUNDEL	10c. City, Town or Location GLEN BURNIE			10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
	10e. Street and Number 543 NOLFIELD DRIVE			10f. Zip Code 21061		10g. Citizen of What Country? U.S.A.		
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: WHITE	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 12		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) HOMEMAKER		16b. Kind of Business/Industry OWN HOME			
To Be Completed by Physician/Medical Examiner	17. Father's Name (First, Middle, Last) FREDERICK EARL O'NEAL				18. Mother's Name (First, Middle, Maiden Surname) GEORGIA ELSIE POLING			
	19a. Informant's Name/Relationship (Type, Print) WILLIAM J. RING - HUSBAND				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 543 NOLFIELD DRIVE, GLEN BURNIE, MD 21061			
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) ARLINGTON NAT. CEM.		Date 2/11/2004		20c. Location - City or Town, State ARLINGTON, VA	
	21. Signature of Funeral Service Licensee KELLY GREGORY FINK #MO1148		22. Name and Address of Facility FINK FUNERAL HOME, PA 426 CRAIN HIGHWAY S., GLEN BURNIE, MD 21061					
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Congestive Heart Failure Due to (or as a consequence of): Ischemic Cardiomyopathy Due to (or as a consequence of): CAD Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last							
	Approximate Interval Between Onset and Death 11 1							
	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 9 <input type="checkbox"/> Unknown 23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) 9 <input type="checkbox"/> Unknown 23d. Date of delivery Month Day Year							
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Type II							
To Be Completed by Physician/Medical Examiner	23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown							
	24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No					
	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
28d. Describe how injury occurred								
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)								
28f. Location (Street and Number or Rural Route Number, City or Town, State)								
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.								
29b. Signature and title of certifier H. J. O'NEAL				29c. License number D35259		29d. Date signed (Month, Day, Year) 2/5/04		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) KEVIN J. O'NEAL 2003 MARYLAND PARKWAY SUITE 100 ANNAPOLIS MD 21401								
State Registrar	31. Date filed (Month, Day, Year) FEB 10 2004				32. Registrar's Signature P. Sparks			

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar AMEND ITEM #10e PER INF G828 2/11/04 Certificate of Death

Reg. No. 2004 03739

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) WILLIAM AUBREY RODGERS				2. Date of Death Month Day Year February 9, 2004				3. Time of Death 4:55 A ^M	
	4a. Facility Name (If not institution, give street and number) Greater Baltimore Medical Center				4b. City, Town, or Location of Death Towson				4c. County of Death Baltimore	
Funeral Director	5. Social Security Number 219-20-3521		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) Yrs. 78		8. Date of Birth (Month, Day, Year) December 10, 1925		9. Birthplace (State or Foreign Country) Maryland	
	Usual Residence of Decedent				10a. State Maryland		10b. County Baltimore		10c. City, Town or Location Towson	
To Be Completed by Funeral Director	10e. Street and Number 8017 STRAUFF ROAD				10f. Zip Code 21204		10g. Citizen of What Country? USA			
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No WWII		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White			
To Be Completed by Physician/Medical Examiner	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Sales				16b. Kind of Business/Industry Insurance	
	17. Father's Name (First, Middle, Last) Harry Winfield Rodgers				18. Mother's Name (First, Middle, Maiden Surname) Constance Jones					
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) William A Rodgers Jr son				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 602 Hastings Road Towson, Maryland 21286					
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Druid Ridge Cemetery		Date 2/12/04		20c. Location - City or Town, State Pikesville, Maryland			
To Be Completed by Physician/Medical Examiner	21. Signature of Funeral Service Licensee Bennis Stephen Kenakis				22. Name and Address of Facility Mitchell-Wiedefeld Funeral Home Inc 6500 York Road Baltimore, Maryland 21212					
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Metastatic Melanoma Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Approximate Interval Between Onset and Death 7 yrs									
To Be Completed by Physician/Medical Examiner	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No 9 <input type="checkbox"/> Unknown				23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) 9 <input type="checkbox"/> Unknown				23d. Date of delivery Month Day Year	
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Invasive Adenocarcinoma of Prostate Insulin Dependent Diabetes Mellitus				23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown					
To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred	
To Be Completed by Physician/Medical Examiner	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. Signature and title of certifier J. W. GLENN, III MD				29c. License number D33400	
	29d. Date signed (Month, Day, Year) 02/09/2004				29e. Name and address of person who completed cause of death (Item 23a) (Type, Print) TREDELL W. GLENN, III MD 6301 N CHARLES ST BALTIMORE MD 21212					
State Registrar	31. Date filed (Month, Day, Year) FEB 10 2004				32. Registrar's Signature [Signature]					

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

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State of Maryland / Department of Health and Mental Hygiene

2004 03740

1- For
State
Registrar

AMEND ITEM #1 PER PHY G828 2/10/04 J

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Mary Riesner MARY RIESNER

2. Date of Death

Month Day Year

February 7 2004

3. Time of Death

1005 A M

4a. Facility Name (If not institution, give street and number)

Northwest Hospital Center

4b. City, Town, or Location of Death

Randallstown

4c. County of Death

Baltimore

Funeral
Director

5. Social Security Number

213-20-6982

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

80 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

Jan 20, 1924

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

MD

10b. County

Baltimore

10c. City, Town or Location

Reisterstown

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

214 Northway Road

10f. Zip Code

21136

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4or 5+)

2

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Housewife

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

Maurice Sturm

18. Mother's Name (First, Middle, Maiden Surname)

Elsie Reid

19a. Informant's Name/Relationship (Type, Print)

Mary Jane Mannion Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1304 Georgetown Drive Bel Air, MD 21014

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Garrison Forest Vet Cem 2/11/04

Date

20c. Location - City or Town, State

Owings Mills, MD

21. Signature of Funeral Service Licensee

Eline Funer

22. Name and Address of Facility

11824 Reisterstown Road
ELINE FUNERAL HOME Reisterstown, MD 21136

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. chronic obstructive pulmonary disease

Due to (or as a consequence of):

b. Pneumonia

Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☒ No
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown3 ☐ Ectopic pregnancy
5 ☐ Other (specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy performed?
1 ☐ Yes 2 ☒ No24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation
2 ☐ Accident 6 ☐ Could not be determined
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day Year)

N/A

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Mayjoy Mejia MD

29c. License number

00060507

29d. Date signed (Month, Day, Year)

February 7 2004

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Mayjoy Mejia, MD 5401 Old Court Road Randallstown, Maryland 21133

31. Date filed (Month, Day, Year)

FEB 10 2004

32. Registrar's Signature

Bryan H. Smith

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

2

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar **AMEND ITEM #19a PER FH G828 2/10/04** **Certificate of Death**

Reg. No. **2004 03741**

Physician / Medical Examiner	1. Decedent's Name (First, Middle, Last) ROSE RODNER		2. Date of Death Month 02 Day 05 Year 2004		3. Time of Death 5 A M
	4a. Facility Name (If not institution, give street and number) Sunrise of Pikesville		4b. City, Town, or Location of Death Pikesville MD		4c. County of Death Baltimore
Funeral Director	5. Social Security Number 213-70-5445	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 86 Yrs.	8. Date of Birth (Month, Day, Year) JUNE 12, 1917	
	9. Birthplace (State or Foreign Country) PALESTINE		10a. State MD		
To Be Completed by Funeral Director	10b. County BALTIMORE		10c. City, Town or Location PIKEVILLE		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
	10e. Street and Number 3800 OLD COURT ROAD		10f. Zip Code 21208		10g. Citizen of What Country? U.S.A.
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:
	14. Race - American Indian, Black, White, etc. Specify: WHITE		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+)		
	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) HOMEMAKER		16b. Kind of Business/Industry OWN HOME		
	17. Father's Name (First, Middle, Last) BENJAMIN LEVIN		18. Mother's Name (First, Middle, Maiden Surname) RACHEL (UNKNOWN)		
	19a. Decedent's Relationship (Type, Print) LESLIE RODNER / SON LES RODNER / SON		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 504 MARKET STREET EAST - GAITHERSBURG, MD 20878		
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) HEBREW YOUNG MEN CEM. 2/8/2004		20c. Location - City or Town, State WOODLAWN, MD
	21. Signature of Funeral Service Licensee <i>Michael Dwyer</i>		22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKEVILLE, MD 21208		
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. ALZHEIMER'S				
23b. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last					
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown					
23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <input checked="" type="checkbox"/> Unknown					
23d. Date of delivery Month Day Year					
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.					
23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown					
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) ASSISTED LIVING					
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined					
28a. Date of Injury (Month, Day Year)					
28b. Time of Injury M					
28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
28d. Describe how injury occurred					
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)					
28f. Location (Street and Number or Rural Route Number, City or Town, State)					
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.					
29b. Signature and title of certifier <i>Walter H. Hines</i>					
29c. License number D23450					
29d. Date signed (Month, Day, Year) 2-5-04					
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Walter Hines MD 5905 Church LA Hydes 21082					
31. Date filed (Month, Day, Year) FEB 10 2004					
32. Registrar's Signature <i>[Signature]</i>					

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

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State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar Amend Item 21 per Dr., 02/10/04 Certificate of Death

Reg. No.

2004 03742

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) MARGARET SIMPSON				2. Date of Death Month Feb. Day 6 Year 2004				3. Time of Death 10:15 P M	
	4a. Facility Name (If not institution, give street and number) Bon Secours Hospital				4b. City, Town, or Location of Death Baltimore				4c. County of Death N/A	
Funeral Director	5. Social Security Number 130-14-0242		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (in yrs. last birthday) 87 Yrs.		8. Date of Birth (Month, Day, Year) Sept. 15, 1916		9. Birthplace (State or Foreign Country) Virginia	
	Usual Residence of Decedent									
To Be Completed by Funeral Director	10a. State Maryland		10b. County N/A		10c. City, Town or Location Baltimore				10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
	10e. Street and Number 4808 Gwynn Oak Ave.				10f. Zip Code 21207		10g. Citizen of What Country? USA			
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: Black		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4or 5+) 0				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker			16b. Kind of Business/Industry Own Home		
To Be Completed by Physician/Medical Examiner	17. Father's Name (First, Middle, Last) William Shepherd				18. Mother's Name (First, Middle, Maiden Surname) Carrie Mae Dykes					
	19a. Informant's Name/Relationship (Type, Name) Ms. Gretchen Simpson (Daughter)				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3768 Columbus Drive Balto. Md. 21215					
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Fairview Cemetery		Date 2/14/2004		20c. Location - City or Town, State Culpepper, Virginia	
	21. Signature of Funeral Service Licensee Joseph L. Russ				22. Name and Address of Facility Joseph L. Russ Funeral Home 2222 W. North Ave. Balto. Md. 21216					
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Congestive Heart Failure Due to (or as a consequence of): b. Pleural Effusion Due to (or as a consequence of): c. Atrial Fibrillation Due to (or as a consequence of): d.									
	23b. Part II. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last									
	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown				23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Unknown <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Other (Specify)				23d. Date of delivery Month Day Year	
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.									
Medical Certification: To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No									
	26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)									
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred	
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)					
State Registrar	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.									
	29b. Signature and title of certifier Jerome Lamb M.D.				29c. License number D37203		29d. Date signed (Month, Day, Year) Feb. 6. 2004			
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Jerome Lamb Bon Secours Hospital, Baltimore Md.									
	31. Date filed (Month, Day, Year) FEB 10 2004				32. Registrar's Signature [Signature]					

Baltimore, Maryland 21215-0036
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2004 03743

1- For
State
Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Charles W. Sprinkle Sr.				2. Date of Death Month Day Year Feb. 4 2004		3. Time of Death 4:00 PM	
	4a. Facility Name (If not institution, give street and number) 127 Daycoach Circle				4b. City, Town, or Location of Death Middle River		4c. County of Death Baltimore	
Funeral Director	5. Social Security Number 217-01-6481		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 88 Yrs.		8. Date of Birth (Month, Day, Year) April 6, 1915	
	9. Birthplace (State or Foreign Country) Maryland							
To Be Completed by Funeral Director	Usual Residence of Decedent		10a. State MD		10b. County Baltimore		10c. City, Town or Location Middle River	
	10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No							
	10e. Street and Number 127 Daycoach Circle				10f. Zip Code 21220		10g. Citizen of What Country? USA	
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12th College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Waymaster		16b. Kind of Business/Industry BethSteel			
	17. Father's Name (First, Middle, Last) Clarence Sprinkle				18. Mother's Name (First, Middle, Maiden Surname) Laura Tyson			
	19a. Informant's Name/Relationship (Type, Print) Robert Sprinkle /son				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 127 Daycoach Circle Baltimore MD			
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Meadowridge Cemetery		20c. Date 2/9/04		20d. Location - City or Town, State Baltimore MD	
	21. Signature of Funeral Service Licensee R. Terry Connelly		22. Name and Address of Facility Connelly Funeral Home of Essex 300 Mace Ave. Baltimore MD 21221					
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. CORONARY ARTERY DISEASE Due to (or as a consequence of): b. HYPERTENSION Due to (or as a consequence of): c. CANCER PROSTATE Due to (or as a consequence of): d. HYPERTENSIVIA							
23b. IF FEMALE: Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown 23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <input type="checkbox"/> Unknown 23d. Date of delivery Month Day Year								
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. OSTEOARTHRITIS								
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								
26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)								
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)						
28f. Location (Street and Number or Rural Route Number, City or Town, State)								
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.								
29b. Signature and title of certifier Saba Siddiqui MD				29c. License number D41496		29d. Date signed (Month, Day, Year) 2/5/2004		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SABA SIDDIQUI 9110 PHILADELPHIA ROAD BALTO MD 21237								
31. Date filed (Month, Day, Year) FEB 10 2004		32. Registrar's Signature [Signature]						

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2004 03744

Certificate of Death.

Reg. No.

1- For
State
RegistrarPhysician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

JAMES ANDREW SMITH, SR.

2. Date of Death

February 6, 2004

3. Time of Death

12:05 PM

4a. Facility Name (If not institution, give street and number)

ST. AGNES HOSPITAL

4b. City, Town, or Location of Death

BALTIMORE

4c. County of Death

n/a

5. Social Security Number

218-10-9196

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

89 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth (Month, Day, Year)

05/09/1914

9. Birthplace (State or Foreign Country)

Virginia

Usual Residence of Decedent

10a. State

MD

10b. County

Baltimore

10c. City, Town or Location

Randallstown

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

4328 Maryridge Drive

10f. Zip Code

21133

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4or 5+)

6th

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Porter

16b. Kind of Business/Industry

Supermarket

17. Father's Name (First, Middle, Last)

Thomas A. Smith

18. Mother's Name (First, Middle, Maiden Surname)

Edna Smith

19a. Informant's Name/Relationship (Type, Print)

Maurice P. Smith

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2379 Flax Terrace, Balto., MD 21209

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Woodlawn Cemetery

Date

2/14/04

20c. Location - City or Town, State

Baltimore, MD

21. Signature of Funeral Service Licensee

W. E. Howell

22. Name and Address of Facility

Howell Funeral Home
4600 Liberty Heights Ave, Balto., MD 21207

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Sepsis
Due to (or as a consequence of):b. Colitis
Due to (or as a consequence of):c. Pneumonia
Due to (or as a consequence of):

d.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Approximate Interval Between Onset and Death

days

days

days

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☒ No
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown3 ☐ Ectopic pregnancy
5 ☐ Other (specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No25. Was case referred to medical examiner?
1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation
2 ☐ Accident 6 ☐ Could not be determined
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☒ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

S. Younis, M.D.

29c. License number

D0060501

29d. Date signed (Month, Day, Year)

February 6, 2004

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Sohair Younis MD

St Agnes Hospital, Baltimore MD

31. Date filed (Month, Day, Year)

FEB 10 2004

32. Registrar's Signature

B. Spahr

State
Registrar

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

JAMES SMITH

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2004 03745

1- For
State
Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Carmen Q. Sheene				2. Date of Death Month Day Year February 7, 2004		3. Time of Death 12:30 A ^M	
	4a. Facility Name (If not institution, give street and number) Continuum Care Of Sykesville				4b. City, Town, or Location of Death Sykesville		4c. County of Death Carroll	
Funeral Director	5. Social Security Number 212-12-2801	6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 84 Yrs.	8. Date of Birth (Month, Day, Year) FEB. 21, 1919		9. Birthplace (State or Foreign Country) Maryland		
	Usual Residence of Decedent							
To Be Completed by Funeral Director	10a. State Maryland		10b. County Carroll		10c. City, Town or Location Westminster		10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
	10e. Street and Number 102 Timber Ridge Drive Apt. 106				10f. Zip Code 21157		10g. Citizen of What Country? USA	
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 2		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Personnel Management		16b. Kind of Business/Industry Electronics			
	17. Father's Name (First, Middle, Last) John G. Windsor				18. Mother's Name (First, Middle, Maiden Surname) Marie R. Goodman			
	19a. Informant's Name/Relationship (Type, Print) Anne Quarles/daughter				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 42 Browns River Road #8 Sayville, NY 11782			
	20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Metro Crematory, Inc.		Date 2/8/04		20c. Location - City or Town, State Baltimore, MD	
	21. Signature of Funeral Service Licensee Thomas Gregor		22. Name and Address of Facility Cremation Society of Maryland, Inc. 299 Frederick Road Baltimore, MD 21228					
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Dementia Due to (or as a consequence of): a. _____ b. _____ c. _____ d. _____ Approximate Interval Between Onset and Death years							
	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 9 <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) _____ 9 <input type="checkbox"/> Unknown				23d. Date of delivery Month Day Year	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown		
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No						
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)						
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28d. Describe how injury occurred						
28f. Location (Street and Number or Rural Route Number, City or Town, State)								
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
29b. Signature and title of certifier John D		29c. License number D47704		29d. Date signed (Month, Day, Year) 2/8/04				
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) TRUNG PHAM MD 4000 OLD GURT RD PIKEVILLE MD								
31. Date filed (Month, Day, Year) FEB 10 2004		32. Registrar's Signature John D						

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification; To Be Completed by Physician/Medical Examiner

Timothy Shelton
04-00975
RJ

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar, Item #23a, 27, 28a-f, Per ME, G88, Certificate of Death

Reg. No. 2004 03746

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Timothy Justin Shelton		2. Date of Death Month Day Year February 3, 2004		3. Time of Death 0420 PM
	4a. Facility Name (If not institution, give street and number) North Arundel Hospital		4b. City, Town, or Location of Death Glen Burnie		4c. County of Death Anne Arundel
Funeral Director	5. Social Security Number 213-15-9543	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 21 Yrs.	8. Date of Birth (Month, Day, Year) Oct 9, 1982	9. Birthplace (State or Foreign Country) MD
	Usual Residence of Decedent				
To Be Completed by Funeral Director	10a. State MD	10b. County Anne Arundel	10c. City, Town or Location Severna Park		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
	10e. Street and Number 167 Barbara Road		10f. Zip Code 21146	10g. Citizen of What Country? USA	
	11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:	13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 10 College (1-4or 5+) 10		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Apprentice		16b. Kind of Business/Industry Construction
To Be Completed by Physician/Medical Examiner	17. Father's Name (First, Middle, Last) Kenneth George Shelton		18. Mother's Name (First, Middle, Maiden Surname) Linda Lee Haycock		
	19a. Informant's Name/Relationship (Type, Print) Mr. Kenneth Shelton / Father		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 167 Barbara Road Severna Park, MD 21146		
	20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Chesapeake Cremation		20c. Location - City or Town, State Stevensville, MD
	21. Signature of Funeral Service Licensee 		22. Name and Address of Facility Singleton Funeral Home, P.A. 1 Second Avenue SW Glen Burnie, MD 21061		
Physician /Medical Examiner	23a. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Narcotic Intoxication Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of):				Approximate Interval Between Onset and Death
	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown				23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Other (specify) 9 Unknown
	23d. Date of delivery Month Day Year				
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				
Medical Certification: To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		
	27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input checked="" type="checkbox"/> Could not be determined	28a. Date of Injury (Month, Day, Year) 03/03/04	28b. Time of Injury 11:05 a.m.	28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	28d. Describe how injury occurred unknown
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) residence		28f. Location (Street and Number or Rural Route Number, City or Town, State) 467 Barbara Rd., Severna Park, MD		
	29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				
State Registrar	29b. Signature and title of certifier 		29c. License number O.C.M.E.		29d. Date signed (Month, Day, Year) February 4, 2004
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) AAA RUBIO, MD 111 Penn Street, Baltimore, Maryland 21201				
31. Date filed (Month, Day, Year) FEB 10 2004		32. Registrar's Signature 			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2004 03747

1- For
State
RegistrarPhysician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Frank Sullivan

2. Date of Death

Month

Day

Year

February 6 2004

3. Time of Death

11:50 AM

Funeral
Director

4a. Facility Name (If not institution, give street and number)

2021 Bay Drive

4b. City, Town, or Location of Death

Pasadena

4c. County of Death

Anne Arundel

5. Social Security Number

217-22-9401

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

76 Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

March 26, 1927

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Anne Arundel

10c. City, Town or Location

Pasadena

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

2021 Bay Drive

10f. Zip Code

21122

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☒ Yes 2 ☐ No
If Yes, Give Year or Dates: WW II

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)
12th Grade

College (1-4or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Lithographer

16b. Kind of Business/Industry

Printing

17. Father's Name (First, Middle, Last)

Frank R. Sullivan, Sr.

18. Mother's Name (First, Middle, Maiden Surname)

Anna C. Lorch

19a. Informant's Name/Relationship (Type, Print)

Mrs. Assunta Sullivan (wife)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2021 Bay Drive, Pasadena, MD 21122

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Balt. Nat'l Cemetery

Date

2/11/2004

20c. Location - City or Town, State

Baltimore, Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Schimunek Funeral Homes

9705 Belair Rd., Baltimore, MD 21236

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Wegener's Granulomatosis

Approximate Interval Between Onset and Death

a. Due to (or as a consequence of):

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☐ No
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 5 ☐ Other (specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D31557

29d. Date signed (Month, Day, Year)

February 6, 2004

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Russell R DeLuna 305 Hospital Drive, A/En Burnie, Md. 21061

31. Date filed (Month, Day, Year)

FEB 10 2004

32. Registrar's Signature

B. Sparks

State Registrar

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene
 AMEND ITEM #19a PER FH G828 2/10/04
 AMEND ITEM #19a PER FH G828 2/10/04
 Reg. No. 2004 03748

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) DENNIS SOBER		2. Date of Death Month 02 Day 05 Year 2004		3. Time of Death 0830A M
	4a. Facility Name (If not institution, give street and number) SINAI HOSPITAL		4b. City, Town, or Location of Death BALTIMORE CITY		4c. County of Death N/A
Funeral Director	5. Social Security Number 215-58-4707	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 50 Yrs.	8. Date of Birth (Month, Day, Year) 09-08-1953	
	9. Birthplace (State or Foreign Country) MD		10a. State MD		
To Be Completed by Funeral Director	10b. County BALTIMORE		10c. City, Town or Location OWINGS MILLS		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
	10e. Street and Number 28 WIMBLEDON LANE		10f. Zip Code 21117		10g. Citizen of What Country? U.S.A.
To Be Completed by Physician/Medical Examiner	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:
	14. Race - American Indian, Black, White, etc. Specify: WHITE		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 4 College (1-4 or 5+)		
To Be Completed by Physician/Medical Examiner	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) MANAGER		16b. Kind of Business/Industry PHARMACY		
	17. Father's Name (First, Middle, Last) HAROLD SOBER		18. Mother's Name (First, Middle, Maiden Surname) BEVERLY BANKS		
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) SUSAN SOBER / WIFE		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 28 WIMBLEDON LANE - OWINGS MILLS, MD 21117		
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) BALTIMORE HEBREW CEM.		20c. Location - City or Town, State REISTERSTOWN, MD
To Be Completed by Physician/Medical Examiner	21. Signature of Funeral Service Licensee <i>Michael Singer</i>		22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208		
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. G. Leukostoma with tumor		Approximate Interval Between Onset and Death		
To Be Completed by Physician/Medical Examiner	23b. Immediate Cause (Final disease or condition resulting in death) G. Leukostoma with tumor		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <input type="checkbox"/> Unknown		
	23d. Date of delivery Month Day Year		23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		
To Be Completed by Physician/Medical Examiner	24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		
To Be Completed by Physician/Medical Examiner	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M
	28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred		
To Be Completed by Physician/Medical Examiner	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)		
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier <i>David Harwood</i>		
To Be Completed by Physician/Medical Examiner	29c. License number RES 000		29d. Date signed (Month, Day, Year) 02-05-2004		
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) David Harwood 2401 W. Belvedere ^ 21215		31. Date filed (Month, Day, Year) FEB 10 2004		
To Be Completed by Physician/Medical Examiner	32. Registrar's Signature <i>James H. [Signature]</i>		33. Date of Death (Month, Day, Year) 02-05-2004		
	34. Date of Death (Month, Day, Year) 02-05-2004		35. Date of Death (Month, Day, Year) 02-05-2004		

Dennis N. Sober
 Baltimore, Maryland 21215-0036
 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,
 To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
 To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2004 03749

1- For
State
RegistrarPhysician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

JOSEPH SILKWORTH

2. Date of Death

FEBRUARY 4 2004 3:00 P.M.

3. Time of Death

4c. County of Death

N/A

4a. Facility Name (If not institution, give street and number)

451 YALE AVENUE

4b. City, Town, or Location of Death

BALTIMORE

Funeral
Director

5. Social Security Number

217 20 5629

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

75

Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

July 16, 1928

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

N/A

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

451 Yale Avenue

10f. Zip Code

21229

10g. Citizen of What Country?

U.S.

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

1 ☐ Yes 2 ☐ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12th

College (1-4 or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working life. DO NOT use retired)

Inspector

16b. Kind of Business/Industry

State of Maryland

17. Father's Name (First, Middle, Last)

(not available)

18. Mother's Name (First, Middle, Maiden Sumame)

(not available)

19a. Informant's Name/Relationship (Type, Print)

Joseph Stinebaugh Sr.

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

4306 Belle Grove Road Baltimore, Maryland 21225

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Bayview Crematory

Date

2/9/2004

20c. Location - City or Town, State

Baltimore, Maryland

21. Signature of Funeral Service Licensee

Piero Aldridge

22. Name and Address of Facility

Gonce Funeral Service, P.A.
4001 Ritchie Highway Baltimore, Maryland 21225

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

COPD

a. Due to (or as a consequence of):

TOBACCO ADDICTION

YEARS

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☐ No9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death4 ☐ Pregnant at time of death9 ☐ Unknown3 ☐ Ectopic pregnancy5 ☐ Other (specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

HTN, ANEMIA, DEPRESSION

23e. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ NoHospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation2 ☐ Accident3 ☐ Suicide4 ☐ Homicide6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Anne Konan, MD

29c. License number

D57284

29d. Date signed (Month, Day, Year)

FEB 5 2004

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ANNA KORZAN 900 CATON AVE BALTIMORE, MD 21229

State
Registrar

31. Date filed (Month, Day, Year)

FEB 10 2004

32. Registrar's Signature

[Signature]

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To Be Completed by Funeral Director

Medical Certification; To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2004 03750

1- For
State
RegistrarPhysician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Ella B. Swinton

2. Date of Death

February 3, 2004

3. Time of Death

1154 P M

Funeral
Director

4a. Facility Name (If not institution, give street and number)

Maryland General Hospital

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

N/A

5. Social Security Number

248-86-7550

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

56 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

June 04 1947

9. Birthplace (State or Foreign Country)

SC

Usual Residence of Decedent

10a. State
Maryland10b. County
N/A

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

501 West Franklin Street

10f. Zip Code

21201

10g. Citizen of What Country?

USA

11. Marital Status

1 ☒ Never Married 2 ☐ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: Black

15. Decedent's Education
(Specify only highest grade completed)Elementary/Secondary (0-12)
Unknown

College (1-4or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Household

17. Father's Name (First, Middle, Last)

James Mann Swinton

18. Mother's Name (First, Middle, Maiden Surname)

Elzina Robinson

19a. Informant's Name/Relationship (Type, Print)

Geraldina Swinton (daughter)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

365 Union ST., Apt B, Hampton, VA 23669

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Rest Haven Cemetery

Date

Feb. 08
2004

20c. Location - City or Town, State

Mullins, SC

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Stallings Funeral Home, P.A.

3111 Mountain Road, Pasadena, MD 21122

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

a. Cerebrovascular Accident

Due to (or as a consequence of):

b. Sepsis

Due to (or as a consequence of):

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

Due to (or as a consequence of):

Approximate
Interval Between
Onset and Death

IF FEMALE:

23b. Was decedent pregnant

in the past 12 months?
1 ☐ Yes 2 ☒ No
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy
4 ☐ Pregnant at time of death 5 ☐ Other (specify)
9 ☐ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an
autopsy
performed?
1 ☐ Yes 2 ☒ No24b. Were autopsy findings available
prior to completion of cause of
death?
1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?1 ☒ Yes 2 ☐ No

Hospital:

1 ☐ Inpatient 2 ☒ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation
6 ☐ Could not be determined

28a. Date of Injury

(Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Hosseini

29c. License number

89474

29d. Date signed (Month, Day, Year)

2/6/04

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Shahrazad Hosseini, M.D. 40 Maryland General Hospital

31. Date filed (Month, Day, Year)

FEB 10 2004

32. Registrar's Signature

Sparks

State
Registrar

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Swinton, Ella
Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2004 03751

1- For
State
Registrar

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Margaret Anna Shiflett		2. Date of Death Month Day Year February 05 2004		3. Time of Death 4:05 A ^M
	4a. Facility Name (If not institution, give street and number) 8388 Oakwood Road		4b. City, Town, or Location of Death Millersville		4c. County of Death Anne Arundel
Funeral Director	5. Social Security Number 219-28-2419	6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 71 Yrs.	8. Date of Birth (Month, Day, Year) June 11 1932	9. Birthplace (State or Foreign Country) MD
	Usual Residence of Decedent				
To Be Completed by Funeral Director	10a. State Maryland	10b. County Anne Arundel	10c. City, Town or Location Millersville		10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
	10e. Street and Number 8388 Oakwood Road		10f. Zip Code 21108		10g. Citizen of What Country? USA
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:
	14. Race - American Indian, Black, White, etc. Specify: White		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 6 College (1-4or 5+)		
	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker		16b. Kind of Business/Industry Household		
To Be Completed by Physician/Medical Examiner	17. Father's Name (First, Middle, Last) Albert Walter Dehn		18. Mother's Name (First, Middle, Maiden Surname) Lillian Unknown		
	19a. Informant's Name/Relationship (Type, Print) Linda L. Shiflett (daughter)		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8388 Oakwood Road, Millersville, MD 21108		
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Cedar Hill Cemetery		20c. Location - City or Town, State Baltimore, Maryland
	21. Signature of Funeral Service Licensee 		22. Name and Address of Facility Stallings Funeral Home, P.A. 3111 Mountain Road, Pasadena, MD 21122		
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Acute myocardial infarction Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. (Disease or injury that initiated events resulting in death) Last				
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 9 <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) 9 <input type="checkbox"/> Unknown		23d. Date of delivery Month Day Year	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Congestive heart failure					
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No					
26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year) M		28b. Time of Injury M	
28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	
28f. Location (Street and Number or Rural Route Number, City or Town, State)		29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.			
29b. Signature and title of certifier 		29c. License number D 23624		29d. Date signed (Month, Day, Year) 02/05/2004	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Basant Khandelwal MD 1600 S. Crain Hwy Glen Burnie MD 21061					
31. Date filed (Month, Day, Year) FEB 10 2004		32. Registrar's Signature 			

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2004 03752

1- For
State
RegistrarPhysician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Regina L. Tracey

2. Date of Death

February 7 2004

3. Time of Death

11:15P.M

4a. Facility Name (If not institution, give street and number)

21 Sorrento Ave.

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

N/A

Funeral
Director

5. Social Security Number

214-22-4621

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

76

8. Date of Birth

09/25/1927

9. Birthplace (State or Foreign Country)

MD

Usual Residence of Decedent

10a. State

MD

10b. County

N/A

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

21 Sorrento Ave.

10f. Zip Code

21229

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify:

White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

Thomas W. Summers

18. Mother's Name (First, Middle, Maiden Surname)

Ellen Winifred Walsh

19a. Informant's Name/Relationship (Type, Print)

Patricia Roescher/Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2208 Alletta Ave. Baltimore, MD 21227

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

New Cathedral Cemetery

Date

02/10/2004

20c. Location - City or Town, State

Baltimore, MD

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Sterling Ashton Schwab Funeral Home, Inc.
736 Edmondson Ave. Baltimore, MD 21228

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Cerebrovascular Accident

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death
1-2 years

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☒ No
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy
4 ☐ Pregnant at time of death 5 ☐ Other (specify)
9 ☐ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Hypertensive Arteriosclerotic Coronary Vascular Disease

Diabetes

Dementia

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOAOther: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation
2 ☐ Accident 6 ☐ Could not be determined
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number

D19667

29d. Date signed (Month, Day, Year)

02-09-2004

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Michael J. Stewart MD 7310 Ritchie Highway # 508 Glen Burnie, Maryland 21061

31. Date filed (Month, Day, Year)

FEB 10 2004

32. Registrar's Signature

State
Registrar

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar Amend Item #5 per fh G828 2/10/04 Certificate of Death

Reg. No.

2004 03753

Physician / Medical Examiner	1. Decedent's Name (First, Middle, Last) FORREST CASPER TAYLOR		2. Date of Death Month FEBRUARY Day 6 Year 2004		3. Time of Death 8:10 A.M.
	4a. Facility Name (If not institution, give street and number) BALTIMORE REHABILITATION EXTENDED CARE		4b. City, Town, or Location of Death BALTIMORE		4c. County of Death N/A
Funeral Director	5. Social Security Number 212-34-0356	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 65 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.
	8. Date of Birth (Month, Day, Year) Sept. 16, 1938		9. Birthplace (State or Foreign Country) MARYLAND		
To Be Completed by Funeral Director	10a. State Maryland		10b. County Baltimore		10c. City, Town or Location WOODLAWN
	10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				
	10e. Street and Number 3807 Byfield Road		10f. Zip Code 21207		10g. Citizen of What Country? USA
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No Korean War If Yes, Give Year or Dates: 1952-1954		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:
	14. Race - American Indian, Black, White, etc. Specify: Black				
To Be Completed by Physician/Medical Examiner	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12th grade College (1-4or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Advertising Marketing J. PETER, Inc.		16b. Kind of Business/Industry
	17. Father's Name (First, Middle, Last) Forrest Alvaugh Taylor		18. Mother's Name (First, Middle, Maiden Surname) Sadie Cornish		
	19a. Informant's Name/Relationship (Type, Print) Jessie Taylor Turk		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3807 Byfield Road Baltimore Maryland 21207		
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Crowsville VA Cemetery		20c. Location - City or Town, State Crowsville, Maryland
	21. Signature of Funeral Service Licensee [Signature]		22. Name and Address of Facility CHARTERED NORTH FORD HOSP 5245 KENNEDY ROAD BALTIMORE, MD 21215		
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) COLON CANCER Due to (or as a consequence of): a. b. c. d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last					Approximate Interval Between Onset and Death 2 years
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown					23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <input type="checkbox"/> Unknown
23d. Date of delivery Month Day Year					
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ENTERO-CUTANEOUS FISTULA DUE TO METASTATIC CANCER					23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.					
29b. Signature and title of certifier Aurora C. Tan, M.D.		29c. License number D14958		29d. Date signed (Month, Day, Year) FEBRUARY 6, 2004	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) AURORA C. TAN 3700 LOCH RAVEN BOULEVARD, BALTIMORE, MD 21218					
31. Date filed (Month, Day, Year) FEB 10 2004		32. Registrar's Signature [Signature]			

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

State Registrar

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2004 03754

1- For
State
Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) THELMA TAYLOR				2. Date of Death Month February Day 6 Year 2004				3. Time of Death 1:45 A M			
	4a. Facility Name (If not institution, give street and number) Maryland General Hospital				4b. City, Town, or Location of Death Baltimore City				4c. County of Death N/A			
Funeral Director	5. Social Security Number 215 16 7789		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 84 Yrs.		8. Date of Birth (Month, Day, Year) DEC. 1, 1919		9. Birthplace (State or Foreign Country) MARYLAND			
	Usual Residence of Decedent											
10a. State MD.		10b. County N/A		10c. City, Town or Location BALTIMORE				10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No				
10e. Street and Number 22-30 ATHOL AVE.				10f. Zip Code 21229				10g. Citizen of What Country? U.S.A.				
11. Marital Status 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:			13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: BLACK			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) UNK College (1-4 or 5+) UNK				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) UNKNOWN				16b. Kind of Business/Industry UNKNOWN				
17. Father's Name (First, Middle, Last) SAMUEL TAYLOR						18. Mother's Name (First, Middle, Maiden Surname) MATTIE BEASLEY						
19a. Informant's Name/Relationship (Type, Print) CHERICE WINKLER (great niece)						19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2212 CLOVILLE AVE. BALTO, MD. 21214						
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) MT. ZION CEM.		Date FEB. 11, 2004		20c. Location - City or Town, State BALTIMORE, MD.				
21. Signature of Funeral Service Licensee <i>Bernadine V. Scruggs</i>						22. Name and Address of Facility CALVIN B. SCRUGGS FUNERAL HOME 1412 E. PRESTON STREET. BALTO, MD. 21213						
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Terminal Aspiration Pneumonia Due to (or as a consequence of): b. Renal Insufficiency Due to (or as a consequence of): c. Due to (or as a consequence of): d. Approximate Interval Between Onset and Death 2 days 4 years												
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 9 <input type="checkbox"/> Unknown			23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) 9 <input type="checkbox"/> Unknown						23d. Date of delivery Month Day Year			
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown				
								24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				
								24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No				
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)									
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide			28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred			
			28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)						28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.												
29b. Signature and title of certifier <i>M. Vasanthakumari</i>						29c. License number D42510		29d. Date signed (Month, Day, Year) 02/06/04				
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) M. VASANTHA-KUMAR MD 4b Maryland General Hospital												
31. Date filed (Month, Day, Year) FEB 10 2004			32. Registrar's Signature <i>[Signature]</i>									

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Thelma Taylor
Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2004 03755

1- For
State
RegistrarPhysician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Helen Tyler

2. Date of Death
Month Day Year

February 8 2004

3. Time of Death
8:01 AM

4a. Facility Name (If not institution, give street and number)

Northwest Hospital

4b. City, Town, or Location of Death

Randallstown

4c. County of Death

Baltimore

Funeral
Director5. Social Security Number
220-03-88136. Sex
1 ☐ M 2 ☒ F7. Age (In yrs. last birthday)
84 Yrs.8. Date of Birth (Month, Day, Year)
July 23, 19199. Birthplace (State or Foreign Country)
MD

Usual Residence of Decedent

10a. State
MD10b. County
Baltimore10c. City, Town or Location
Owings Mills10d. Inside City Limits
1 ☐ Yes 2 ☒ No

10e. Street and Number

4 Beth Court

10f. Zip Code

21117

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced12. Was Decedent Ever in U.S.
Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.
Specify: White15. Decedent's Education
(Specify only highest grade completed)Elementary/Secondary (0-12)
12

College (1-4 or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Secretary

16b. Kind of Business/Industry

Office

17. Father's Name (First, Middle, Last)

George Jankowski

18. Mother's Name (First, Middle, Maiden Surname)

Thelma Holmes

19a. Informant's Name/Relationship (Type, Print)

Beverly Tyler Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

4 Beth Court, Owings Mills, MD 21117

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Crestlawn Cemetery

Date

2/11/04

20c. Location - City or Town, State

Marriottsville, MD

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

11824 Reisterstown Road
Eline Funeral Home Reisterstown, MD 2113623a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

a. Multiple organ system failure

Due to (or as a consequence of):

Approximate
Interval Between
Onset and Death
24 hoursSequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

b. Systemic inflammatory response syndrome

Due to (or as a consequence of):

48 hours

c. Ischemic bowel disease

Due to (or as a consequence of):

48 hours

IF FEMALE:

23b. Was decedent pregnant
in the past 12 months?
1 ☐ Yes 2 ☒ No
9 ☐ Unknown23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 5 ☐ Other (specify)
9 ☐ Unknown3 ☐ Ectopic pregnancy23d. Date of delivery
Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Type II diabetes mellitus // Chronic kidney disease
Chronic obstructive pulmonary disease
Hypothyroidism // Valvular cardiomyopathy23e. Did tobacco use contribute to the cause of death?
1 ☐ Yes 2 ☐ No 3 ☒ Probably 4 ☐ Unknown24a. Was an
autopsy
performed?
1 ☐ Yes 2 ☒ No24b. Were autopsy findings available
prior to completion of cause of
death?
1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?
1 ☐ Yes 2 ☒ NoHospital: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending
investigation
2 ☐ Accident 6 ☐ Could not be
determined
3 ☐ Suicide 4 ☐ Homicide28a. Date of Injury
(Month, Day, Year)28b. Time of
injury28c. Injury at
Work?
1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

J. Boston MD

29c. License number

D28462

29d. Date signed (Month, Day, Year)

February 8, 2004

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

J Boston Northwest Hospital Center Randallstown, Maryland 21133

31. Date filed (Month, Day, Year)

FEB 10 2004

32. Registrar's Signature

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or item 23a or 28a-f show
any injury or other traumatic event, the Medical Examiner must be notified at
once.Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2004 03756

1- For
State
RegistrarPhysician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Mary D. Wilder

2. Date of Death

Month Day Year
Feb 4 2004

3. Time of Death

1:51 PM

Funeral
Director

4a. Facility Name (If not institution, give street and number)

Union Memorial

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

Baltimore

5. Social Security Number

213-62-7187

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

49 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
4-15-54

9. Birthplace (State or Foreign Country)

MD

Usual Residence of Decedent

10a. State
MD

10b. County

Baltimore

10c. City, Town or Location

Windsor Mill

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

106 Village of Pine Ct Apt 20

10f. Zip Code

21244

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: BLACK

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4or 5+)

12th16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Adm & Security Specialist

16b. Kind of Business/Industry

Banking

17. Father's Name (First, Middle, Last)

Arthur Blackburn

18. Mother's Name (First, Middle, Maiden Surname)

Anna Tucker

19a. Informant's Name/Relationship (Type, Print)

Bobby Wilder/Husband

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

106 Village of Pine Ct Apt 20 Baltimore MD 21244

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Garrison Forest

Date

2-12-04

20c. Location - City or Town, State

Dwight Mills, MD

21. Signature of Funeral Service Licensee

Vaughn C. Greene

22. Name and Address of Facility

Vaughn C. Greenleaf Services
8928 Liberty Rd Randallstown, MD 2113323a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)a. Acute MI
Due to (or as a consequence of):b. Hypoxemia
Due to (or as a consequence of):c. Hypoxia
Due to (or as a consequence of):d.
Due to (or as a consequence of):Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) LastApproximate
Interval Between
Onset and Death

IF FEMALE:

23b. Was decedent pregnant

in the past 12 months?
1 ☐ Yes 2 ☒ No
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy
4 ☐ Pregnant at time of death 5 ☐ Other (specify)
9 ☐ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

1/1/04 S/P stroke, S/P TAAA Stent
S/P OCEA, H/O HTN, GERD, Thyroid
Cyst., S/P PEG, Anemia

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an
autopsy
performed?1 ☒ Yes 2 ☐ No24b. Were autopsy findings available
prior to completion of cause of
death?1 ☐ Yes 2 ☒ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending
investigation
2 ☐ Accident 6 ☐ Could not be
determined
3 ☐ Suicide
4 ☐ Homicide28a. Date of Injury
(Month, Day Year)28b. Time of
Injury28c. Injury at
Work?
1 ☐ Yes 2 ☒ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
and manner stated.

29b. Signature and title of certifier

D. L. L. M.

29c. License number

D0057864

29d. Date signed (Month, Day, Year)

2/4/04

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Dorel Snow, M.D. Union Memorial Hospital, Baltimore MD 21218

31. Date filed (Month, Day, Year)

FEB 10 2004

32. Registrar's Signature

D. L. L. M.

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

Baltimore, Maryland 21215-0036
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or item 23a or 28a-f show
any injury or other traumatic event, the Medical Examiner must be notified at
once.To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit
certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2004 03757

1- For
State
RegistrarPhysician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last) Florence Williams 2. Date of Death Month 2 Day 4 Year 04 3. Time of Death 8:40 AM

Funeral
Director

4a. Facility Name (If not institution, give street and number) Manor Care Nursing Home 4b. City, Town, or Location of Death BALTIMORE 4c. County of Death MD

5. Social Security Number 212-28-8104 6. Sex ☐ M ☒ F 7. Age (In yrs. last birthday) 93 Yrs. 8. Date of Birth (Month, Day, Year) 4-18-10 9. Birthplace (State or Foreign Country) MD

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State MD 10b. County BALTIMORE 10c. City, Town or Location BALTIMORE 10d. Inside City Limits ☒ Yes ☐ No

10e. Street and Number 3406 Carlisle Ave 10f. Zip Code 21216 10g. Citizen of What Country? USA

11. Marital Status ☐ Never Married ☐ Married ☒ Widowed ☐ Divorced 12. Was Decedent Ever in U.S. Armed Forces? ☐ Yes ☒ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) ☐ Yes ☒ No Specify: 14. Race - American Indian, Black, White, etc. Specify: BLACK

15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 8 College (1-4or 5+) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Nursing 16b. Kind of Business/Industry Health Care

17. Father's Name (First, Middle, Last) JOHN SNEED 18. Mother's Name (First, Middle, Maiden Surname) Bessie Pratt

19a. Informant's Name/Relationship (Type, Print) Rosann Collins/Daughter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3407 Carlisle Ave BALTIMORE, MD 21216

20a. Method of Disposition ☒ Burial ☐ Cremation ☐ Removal from State ☐ Donation ☐ Other (Specify) 20b. Place of Disposition (Name of cemetery, crematory or other place) London Park Date 2-10-04 20c. Location - City or Town, State BALTIMORE MD

21. Signature of Funeral Service Licensee Vaughn C. Greene 22. Name and Address of Facility Vaughn C. Greene Funeral Services 8728 Liberty Rd Randallstown, MD 21133

Physician
/Medical
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Cerebral vascular accident Approximate Interval Between Onset and Death Unknown

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

a. Due to (or as a consequence of):
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d. Due to (or as a consequence of):

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? ☐ Yes ☒ No ☐ Unknown 23c. If yes, outcome of pregnancy ☐ Live birth ☐ Fetal death ☐ Ectopic pregnancy ☐ Pregnant at time of death ☐ Other (specify) 23d. Date of delivery Month 2 Day 10 Year 04

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Bev Hypertension 23e. Did tobacco use contribute to the cause of death? ☐ Yes ☒ No ☐ Probably ☐ Unknown

24a. Was an autopsy performed? ☐ Yes ☒ No 24b. Were autopsy findings available prior to completion of cause of death? ☐ Yes ☒ No

25. Was case referred to medical examiner? ☐ Yes ☒ No 26. Place of Death (Check only one) Hospital: ☐ Inpatient ☐ ER/Outpatient ☐ DOA Other: ☒ Nursing Home ☐ Residence ☐ Other (Specify)

27. Manner of Death ☒ Natural ☐ Accident ☐ Suicide ☐ Homicide ☐ Pending investigation ☐ Could not be determined 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury M 28c. Injury at Work? ☐ Yes ☒ No 28d. Describe how injury occurred 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier MD 29c. License number MD27569 29d. Date signed (Month, Day, Year) 2/17/04

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Allen Nettlesman 1838 Greene Tree Rd 21208

31. Date filed (Month, Day, Year) FEB 10 2004 32. Registrar's Signature [Signature]

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filed in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2004 03758

Physician Medical Examiner	1. Decedent's Name (First, Middle, Last) Edith Mary Whetzel				2. Date of Death Month Day Year Feb 8 2004		3. Time of Death 8:40 AM		
	4a. Facility Name (If not institution, give street and number) University of Maryland Specialty Hospital				4b. City, Town, or Location of Death Baltimore		4c. County of Death N/A		
Funeral Director	5. Social Security Number 212-26-5284		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 83 Yrs.		8. Date of Birth (Month, Day, Year) AUG 26, 1920		
	9. Birthplace (State or Foreign Country) West Virginia		10a. State Maryland		10b. County Baltimore		10c. City, Town or Location Catonsville		
Usual Residence of Decedent		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		10e. Street and Number 2B Merrill Road		10f. Zip Code 21228		10g. Citizen of What Country? USA	
11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 10 College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Waitress		16b. Kind of Business/Industry Restaurant		17. Father's Name (First, Middle, Last) John Whetzel		18. Mother's Name (First, Middle, Maiden Surname) Emma Dove	
19a. Informant's Name/Relationship (Type, Print) Shirley M. Whetzel/daughter		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2B Merrill Road Catonsville, MD 21228		20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Liberty Baptist Cemetery		20c. Location - City or Town, State Lisbon, MD	
21. Signature of Funeral Service Licensee Dawn F. McDonald		22. Name and Address of Facility MacNabb Funeral Home, P.A. 301 Frederick Road Baltimore, MD 21228		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Cardiac arrhythmias Due to (or as a consequence of): b. congestive heart failure Due to (or as a consequence of): c. hypertension Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last e. f. g. h. i. j. k. l. m. n. o. p. q. r. s. t. u. v. w. x. y. z. aa. ab. ac. ad. ae. af. ag. ah. ai. aj. ak. al. am. an. ao. ap. aq. ar. as. at. au. av. aw. ax. ay. az. ba. bb. bc. bd. be. bf. bg. bh. bi. bj. bk. bl. bm. bn. bo. bp. bq. br. bs. bt. bu. bv. bw. bx. by. bz. ca. cb. cc. cd. ce. cf. cg. ch. ci. cj. ck. cl. cm. cn. co. cp. cq. cr. cs. ct. cu. cv. cw. cx. cy. cz. da. db. dc. dd. de. df. dg. dh. di. dj. dk. dl. dm. dn. do. dp. dq. dr. ds. dt. du. dv. dw. dx. dy. dz. ea. eb. ec. ed. ee. ef. eg. eh. ei. ej. ek. el. em. en. eo. ep. eq. er. es. et. eu. ev. ew. ex. ey. ez. fa. fb. fc. fd. fe. ff. fg. fh. fi. fj. fk. fl. fm. fn. fo. fp. fq. fr. fs. ft. fu. fv. fw. fx. fy. fz. ga. gb. gc. gd. ge. gf. gg. gh. gi. gj. gk. gl. gm. gn. go. gp. gq. gr. gs. gt. gu. gv. gw. gx. gy. gz. ha. hb. hc. hd. he. hf. hg. hh. hi. hj. hk. hl. hm. hn. ho. hp. hq. hr. hs. ht. hu. hv. hw. hx. hy. hz. ia. ib. ic. id. ie. if. ig. ih. ii. ij. ik. il. im. in. io. ip. iq. ir. is. it. iu. iv. iw. ix. iy. iz. ja. jb. jc. jd. je. jf. jg. jh. ji. jj. jk. jl. jm. jn. jo. jp. jq. jr. js. jt. ju. jv. jw. jx. jy. jz. ka. kb. kc. kd. ke. kf. kg. kh. ki. kj. kk. kl. km. kn. ko. kp. kq. kr. ks. kt. ku. kv. kw. kx. ky. kz. la. lb. lc. ld. le. lf. lg. lh. li. lj. lk. ll. lm. ln. lo. lp. lq. lr. ls. lt. lu. lv. lw. lx. ly. lz. ma. mb. mc. md. me. mf. mg. mh. mi. mj. mk. ml. mm. mn. mo. mp. mq. mr. ms. mt. mu. mv. mw. mx. my. mz. na. nb. nc. nd. ne. nf. ng. nh. ni. nj. nk. nl. nm. nn. no. np. nq. nr. ns. nt. nu. nv. nw. nx. ny. nz. oa. ob. oc. od. oe. of. og. oh. oi. oj. ok. ol. om. on. oo. op. oq. or. os. ot. ou. ov. ow. ox. oy. oz. pa. pb. pc. pd. pe. pf. pg. ph. pi. pj. pk. pl. pm. pn. po. pp. pq. pr. ps. pt. pu. pv. pw. px. py. pz. qa. qb. qc. qd. qe. qf. qg. qh. qi. qj. qk. ql. qm. qn. qo. qp. qq. qr. qs. qt. qu. qv. qw. qx. qy. qz. ra. rb. rc. rd. re. rf. rg. rh. ri. rj. rk. rl. rm. rn. ro. rp. rq. rr. rs. rt. ru. rv. rw. rx. ry. rz. sa. sb. sc. sd. se. sf. sg. sh. si. sj. sk. sl. sm. sn. so. sp. sq. sr. ss. st. su. sv. sw. sx. sy. sz. ta. tb. tc. td. te. tf. tg. th. ti. tj. tk. tl. tm. tn. to. tp. tq. tr. ts. tt. tu. tv. tw. tx. ty. tz. ua. ub. uc. ud. ue. uf. ug. uh. ui. uj. uk. ul. um. un. uo. up. uq. ur. us. ut. uu. uv. uw. ux. uy. uz. va. vb. vc. vd. ve. vf. vg. vh. vi. vj. vk. vl. vm. vn. vo. vp. vq. vr. vs. vt. vu. vv. vw. vx. vy. vz. wa. wb. wc. wd. we. wf. wg. wh. wi. wj. wk. wl. wm. wn. wo. wp. wq. wr. ws. wt. wu. wv. ww. wx. wy. wz. xa. xb. xc. xd. xe. xf. xg. xh. xi. xj. xk. xl. xm. xn. xo. xp. xq. xr. xs. xt. xu. xv. xw. xx. xy. xz. ya. yb. yc. yd. ye. yf. yg. yh. yi. yj. yk. yl. ym. yn. yo. yp. yq. yr. ys. yt. yu. yv. yw. yx. yy. yz. za. zb. zc. zd. ze. zf. zg. zh. zi. zj. zk. zl. zm. zn. zo. zp. zq. zr. zs. zt. zu. zv. zw. zx. zy. zz.					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2004 03759

1- For
State
RegistrarPhysician
/Medical
ExaminerFuneral
Director

1. Decedent's Name (First, Middle, Last) Edward A. Wendler		2. Date of Death Month February Day 8 Year 2004		3. Time of Death 3:40 P	
4a. Facility Name (If not institution, give street and number) Eastpoint Nursing & Rehab. Ctr.		4b. City, Town, or Location of Death Eastpoint		4c. County of Death Baltimore Co.	
5. Social Security Number 212-16-6493	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 82 Yrs.	8. Date of Birth (Month, Day, Year) March 3, 1921		9. Birthplace (State or Foreign Country) Maryland
Usual Residence of Decedent					
10a. State Maryland	10b. County N/A	10c. City, Town or Location Baltimore City		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
10e. Street and Number 3501 St. Paul Street Apt. 1045		10f. Zip Code 21218		10g. Citizen of What Country? United States	
11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: WWII		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:	
14. Race - American Indian, Black, White, etc. Specify: White		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 11 Years College (1-4 or 5+) College			
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Brakeman		16b. Kind of Business/Industry Railroad			
17. Father's Name (First, Middle, Last) Paul Wendler			18. Mother's Name (First, Middle, Maiden Surname) Agnes M. Yingling		
19a. Informant's Name/Relationship (Type, Print) Mrs. Ida M. Brown (Sister)			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7724 North Point Road Edgemere, Maryland 21219		
20a. Method of Disposition <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input checked="" type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Hilltop Service Corp.		20c. Location - City or Town, State 2/12/2004 Towson, Maryland	
21. Signature of Funeral Service Licensee 		22. Name and Address of Facility Juda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 21222			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Ventricular Arrhythmia Due to (or as a consequence of): Hyper tension Atherosclerotic Cardiovascular Disease 5yrs Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):					
IF FEMALE 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input checked="" type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify)		23d. Date of delivery Month Day Year	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.					
23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown					
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M	
28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred			
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.					
29b. Signature and title of certifier 		29c. License number D394660		29d. Date signed (Month, Day, Year) February 9 2004	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Walter Norm Point Rd. Baltimore MD 21219					
31. Date filed (Month, Day, Year) FEB 10 2004		32. Registrar's Signature 			

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "Natural," or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

State
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2004 03760

1- For
State
RegistrarPhysician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

THOMAS A. WASHINGTON JR.

2. Date of Death

Month Day Year
FEBRUARY 8, 2004

3. Time of Death

11:10 PM

4a. Facility Name (If not institution, give street and number)

Saint Joseph Medical Center

4b. City, Town, or Location of Death

Towson

4c. County of Death

Baltimore

Funeral
Director

5. Social Security Number

213-36-3689

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

64 Yrs.

If Under 1 Year

Months

If Under 24 Hrs.

Hours

8. Date of Birth

(Month, Day, Year)
OCTOBER 30, 1940

9. Birthplace (State or Foreign Country)

MARYLAND

Usual Residence of Decedent

10a. State

MD

10b. County

10c. City, Town or Location

BALTIMORE

10d. Inside City Limits

☒ Yes ☐ No

10e. Street and Number

5518 MAYVIEW AVE.

10f. Zip Code

21206

10g. Citizen of What Country?

U.S.A.

11. Marital Status

☐ Never Married ☒ Married
☐ Widowed ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

☐ Yes ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

☐ Yes ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: BLACK

15. Decedent's Education (Specify only highest grade completed)

Elementary/High (0-12)

College (1-4or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

SUPERVISOR

16b. Kind of Business/Industry

INDUSTRIAL

17. Father's Name (First, Middle, Last)

THOMAS WASHINGTON SR.

18. Mother's Name (First, Middle, Maiden Surname)

LOU ELLA SHAW

19a. Informant's Name/Relationship (Type, Print)

PATRICIA WASHINGTON /WIFE

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

5518 MAYVIEW AVE. BALTIMORE, MD 21206

20a. Method of Disposition

☒ Burial ☐ Cremation ☐ Removal from State
☐ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

KING MEMORIAL PARK

Date

2-14-04

20c. Location - City or Town, State

BALTIMORE, MARYLAND

21. Signature of Funeral Service Licensee

Kerry Pruitt

22. Name and Address of Facility

VAUGHN C. GREENE FUNERAL HOME

4905 YORK ROAD BALTIMORE, MARYLAND 21212

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. CARDIAC TAMPONADE

Due to (or as a consequence of):

b. ACUTE MYOCARDIAL INFARCTION

Due to (or as a consequence of):

c. HYPERTENSION

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Approximate Interval Between Onset and Death
2 DAYS

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

☐ Yes ☒ No ☐ Unknown

23c. If yes, outcome of pregnancy

☐ Live birth ☐ Fetal death ☐ Ectopic pregnancy
☐ Pregnant at time of death ☐ Other (specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

HYPERLIPIDEMIA

DIABETES MELLITUS

23e. Did tobacco use contribute to the cause of death?

☐ Yes ☒ No ☐ Probably ☐ Unknown

24a. Was an autopsy performed?

☐ Yes ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

☐ Yes ☒ No

25. Was case referred to medical examiner?

☐ Yes ☒ No

26. Place of Death (Check only one)

Hospital: ☒ Inpatient ☐ ER/Outpatient ☐ DOA Other: ☐ Nursing Home ☐ Residence ☐ Other (Specify)

27. Manner of Death

☒ Natural ☐ Pending investigation
☐ Accident ☐ Could not be determined
☐ Suicide ☐ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

☐ Yes ☒ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Kerry Pruitt MD

29c. License number

D 0057329

29d. Date signed (Month, Day, Year)

Feb 9, 2004

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

KERRY PRUITT M.D. 7601 OLIVER DRIVE TOWSON MARYLAND 21204

31. Date filed (Month, Day, Year)

FEB 10 2004

32. Registrar's Signature

Kerry Pruitt

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

State
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2004 03761

1- For
State
Registrar

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Physician
/Medical
ExaminerFuneral
Director

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

1. Decedent's Name (First, Middle, Last) <u>Edward J. Weckesser Sr.</u>		2. Date of Death Month <u>February</u> Day <u>7th</u> Year <u>2004</u>		3. Time of Death <u>2:47AM</u>	
4a. Facility Name (If not institution, give street and number) <u>Northwest Hospital Center</u>		4b. City, Town, or Location of Death <u>Randallstown</u>		4c. County of Death <u>Baltimore</u>	
5. Social Security Number <u>218-12-8346</u>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <u>79</u> Yrs.	
8. Date of Birth (Month, Day, Year) <u>May 21, 1924</u>		9. Birthplace (State or Foreign Country) <u>Maryland</u>			
Usual Residence of Decedent					
10a. State <u>MD</u>		10b. County <u>Baltimore</u>		10c. City, Town or Location <u>Baltimore</u>	
10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
10e. Street and Number <u>2927 Rolling Road</u>		10f. Zip Code <u>21244</u>		10g. Citizen of What Country? <u>U. S. A.</u>	
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: <u>WWII</u>		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:	
14. Race - American Indian, Black, White, etc. Specify: <u>White</u>		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <u>7</u> College (1-4or 5+) <u>0</u>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <u>Tile Setter</u>	
16b. Kind of Business/Industry <u>Construction</u>		17. Father's Name (First, Middle, Last) <u>Harry Weckesser</u>		18. Mother's Name (First, Middle, Maiden Surname) <u>Tillie Heck</u>	
19a. Informant's Name/Relationship (Type, Print) <u>Jerry L. Weckesser Son</u>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>183 Sara Lane, Hanover, Pennsylvania 17331</u>			
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <u>Lorraine Park</u>		20c. Date <u>02/11/04</u>	
20d. Location - City or Town, State <u>Woodlawn, Maryland 21207</u>		21. Signature of Funeral Service Licensee <u>[Signature]</u>		22. Name and Address of Facility <u>Loring Byers Funeral Directors Inc</u> <u>8728 Liberty Road, Randallstown, MD. 21133-4784</u>	
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. <u>GI bleed</u> Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last					
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <input type="checkbox"/> Unknown		23d. Date of delivery Month Day Year	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>COPD</u> <u>Pneumonia</u>				23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown	
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <u>M</u>	
28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		28d. Describe how injury occurred			
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.					
29b. Signature and title of certifier <u>[Signature]</u>		29c. License number <u>D0056032</u>		29d. Date signed (Month, Day, Year) <u>February 7th 2004</u>	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <u>Lt. Gerald Jean mo</u> <u>5401 Old Court Rd Randallstown, MD 21133</u>					
31. Date filed (Month, Day, Year) <u>FEB 10 2004</u>		32. Registrar's Signature <u>[Signature]</u>			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2004 03762

1- For
State
RegistrarPhysician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

JESSE WARREN

2. Date of Death
Month Day Year
FEBRUARY 03 20043. Time of Death
11:00 P M

4a. Facility Name (If not institution, give street and number)

Northwest Hospital

4b. City, Town, or Location of Death

Randallstown

4c. County of Death

Baltimore

Funeral
Director

5. Social Security Number

215-28-6675

6. Sex

M ☒ F ☐

7. Age (In yrs. last birthday)

70

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth (Month, Day, Year)

11 28 33

9. Birthplace (State or Foreign Country)

MD

Usual Residence of Decedent

10a. State

MD

10b. County

NA

10c. City, Town or Location

Baltimore

10d. Inside City Limits

☒ Yes ☐ No

10e. Street and Number

5006 Levindale Road

10f. Zip Code

21215

10g. Citizen of What Country?

U.S.A

11. Marital Status

☐ Never Married ☒ Married
☐ Widowed ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

☒ Yes ☐ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

☐ Yes ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12th grade

College (1-4or 5+)

na

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Supervisor

16b. Kind of Business/Industry

Coppin State College

17. Father's Name (First, Middle, Last)

North Warren

18. Mother's Name (First, Middle, Maiden Surname)

Ruby Gee

19a. Informant's Name/Relationship (Type, Print)

Rebecca Warren-Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

5006 Levindale Road, Baltimore Md 21215

20a. Method of Disposition

☒ Burial ☐ Cremation ☐ Removal from State
☐ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Garrison Forest Vet. 2/11/04 Owing Mills, Md

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

Ida Marsh

22. Name and Address of Facility

March F/H West
4300 Wabash Ave, Baltimore Md 21215

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Due to (or as a consequence of):

SEPSIS

b. Due to (or as a consequence of):

CHRONIC RENAL FAILURE

c. Due to (or as a consequence of):

DIABETES MELLITUS.

d. Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Approximate Interval Between Onset and Death

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

☐ Yes ☒ No
☐ Unknown

23c. If yes, outcome of pregnancy

☐ Live birth ☐ Fetal death
☐ Pregnant at time of death
☐ Unknown3 ☐ Ectopic pregnancy5 ☐ Other (specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

☐ Yes ☒ No ☐ Probably ☒ Unknown24a. Was an autopsy performed?
☐ Yes ☒ No24b. Were autopsy findings available prior to completion of cause of death?
☐ Yes ☒ No25. Was case referred to medical examiner?
☐ Yes ☒ No

Hospital:

☒ Inpatient ☐ ER/Outpatient ☐ DOA

26. Place of Death (Check only one)

Other: ☐ Nursing Home ☐ Residence ☐ Other (Specify)

27. Manner of Death

☒ Natural ☐ Pending investigation
☐ Accident ☐ Could not be determined
☐ Suicide ☐ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

☐ Yes ☒ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Joginder P Mehta MD

29c. License number

D0041410

29d. Date signed (Month, Day, Year)

February 04th 2004

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Joginder P Mehta

Northwest Hospital Center Randallstown MD 21133

31. Date filed (Month, Day, Year)

FEB 10 2004

32. Registrar's Signature

Joginder P Mehta

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 687607

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2004 03763

1- For
State
RegistrarPhysician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Nancy Adeline Ward

2. Date of Death

February 6, 2004

3. Time of Death

8:00 P^MFuneral
Director

4a. Facility Name (If not institution, give street and number)

Stella Maris

4b. City, Town, or Location of Death

Timonium

4c. County of Death

Baltimore

5. Social Security Number

212-05-1467

6. Sex

☐ M ☒ F

7. Age (In yrs. last birthday)

93 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
July 29, 1910

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Baltimore

10c. City, Town or Location

Timonium

10d. Inside City Limits

☐ Yes ☒ No

10e. Street and Number

2300 Dulaney Valley Rd.

10f. Zip Code

21093

10g. Citizen of What Country?

United States

11. Marital Status

☐ Never Married ☐ Married
☒ Widowed ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

☐ Yes ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

☐ Yes ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: white

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

10

College (1-4or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

accounting representative

16b. Kind of Business/Industry

phone company

17. Father's Name (First, Middle, Last)

Francis Macatee Quinn

18. Mother's Name (First, Middle, Maiden Surname)

Elizabeth Smith

19a. Informant's Name/Relationship (Type, Print)

Michael E. Ward/son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

4 Bandon Ct., #303 Timonium, MD 21093

20a. Method of Disposition

☒ Burial ☐ Cremation ☐ Removal from State
☐ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

New Cathedral Cemetery

Date

Feb. 11, 2004

20c. Location - City or Town, State

Baltimore, Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Mitchell-Wiedefeld Funeral Home, Inc.
6500 York Rd. Baltimore, MD 21212

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Due to (or as a consequence of):

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Approximate Interval Between Onset and Death

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

☐ Yes ☒ No
☐ Unknown

23c. If yes, outcome of pregnancy

☐ Live birth ☐ Fetal death ☐ Ectopic pregnancy
☐ Pregnant at time of death ☐ Other (specify)
☐ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

☐ Yes ☒ No ☐ Probably ☒ Unknown

24a. Was an autopsy performed?

☐ Yes ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

☐ Yes ☒ No

25. Was case referred to medical examiner?

☐ Yes ☒ No

26. Place of Death (Check only one)

Hospital: ☐ Inpatient ☐ ER/Outpatient ☐ DOA Other: ☒ Nursing Home ☐ Residence ☐ Other (Specify)

27. Manner of Death

☒ Natural ☐ Pending investigation
☐ Accident ☐ Could not be determined
☐ Suicide ☐ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

☐ Yes ☒ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

115504

29d. Date signed (Month, Day, Year)

2.09.04

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

EDDIE NAKHUDA, M.D. 2300 DULANEY VALLEY ROAD TIMONIUM, MD 21093

State
Registrar

31. Date filed (Month, Day, Year)

FEB 10 2004

32. Registrar's Signature

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transitNANCY WARD FEBRUARY 6, 2004 8:00 P.M.
Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2004 03764

1- For
State
RegistrarPhysician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

William L. Willett, Jr.

2. Date of Death

February 6 2004

3. Time of Death

6:10 P.M.

4a. Facility Name (If not institution, give street and number)

731 Winton Avenue

4b. City, Town, or Location of Death

Glen Burnie

4c. County of Death

Anne Arundel

5. Social Security Number

216 42 2897

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

60

If Under 1 Year

Months

If Under 24 Hrs.

Days

Hours

Min.

8. Date of Birth

July 18, 1943

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Anne Arundel

10c. City, Town or Location

Glen Burnie

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

731 Winton Avenue

10f. Zip Code

21060

10g. Citizen of What Country?

U.S.

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☒ Yes 2 ☐ No
If Yes, Give Year or Dates: Viet Nam

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

1 year

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Mechanic

16b. Kind of Business/Industry

Domino Sugar

17. Father's Name (First, Middle, Last)

William L. Willett, Sr.

18. Mother's Name (First, Middle, Maiden Surname)

Phyllis Leona Bowen

19a. Informant's Name/Relationship (Type, Print)

Suzanne Willett / wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

731 Winton Avenue Glen Burnie, Maryland 21061

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Meadowridge Mem. Park

Date

2/10/2004

20c. Location - City or Town, State

Elkridge, Maryland

21. Signature of Funeral Service Licensee

Sharon Liggert

22. Name and Address of Facility

Gonce Funeral Service, P.A.
4001 Ritchie Highway Baltimore, Maryland 21225

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. CARDIAC ARREST

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. CORONARY ARTERY DISEASE

Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death
minutes

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 5 ☐ Other (specify)
9 ☐ Unknown23d. Date of delivery
Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

ALCOHOLISM

CHRONIC OBSTRUCTIVE PULMONARY DISEASE

PERIPHERAL VASCULAR DISEASE

23e. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy performed?
1 ☐ Yes 2 ☒ No24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation
2 ☐ Accident 6 ☐ Could not be determined
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

2 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Jan K. Sigman MD

29c. License number

033231

29d. Date signed (Month, Day, Year)

02/09/2004

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

SAN KSEDAW MD 8028 Ritchie Hwy, PARADENA MD 21122

31. Date filed (Month, Day, Year)

FEB 10 2004

32. Registrar's Signature

Jan K. Sigman

State
Registrar

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

1- For
State
Registrar

2004 03765

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Milton Williams			2. Date of Death Month February Day 8 Year 2004		3. Time of Death 11:00 A.M	
	4a. Facility Name (If not institution, give street and number) Genesis Eldercare Hammonds Lane			4b. City, Town, or Location of Death Baltimore		4c. County of Death Anne Arundel	
Funeral Director	5. Social Security Number 218 03 9979		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (in yrs. last birthday) 83 Yrs.		8. Date of Birth (Month, Day, Year) Sept. 22, 1920	
	9. Birthplace (State or Foreign Country) Maryland						
To Be Completed by Funeral Director	Usual Residence of Decedent						
	10a. State Maryland	10b. County Anne Arundel	10c. City, Town or Location Baltimore			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	10e. Street and Number 208 - 7th Avenue			10f. Zip Code 21225		10g. Citizen of What Country? U.S.	
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: WW II		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 10th			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Stero Typist		16b. Kind of Business/Industry Sun Paper	
	17. Father's Name (First, Middle, Last) Milton J. Williams, Sr.			18. Mother's Name (First, Middle, Maiden Surname) Annie Michael			
	19a. Informant's Name/Relationship (Type, Print) Joan Rafferty / Daughter			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 208 - 7th Avenue Baltimore, Maryland 21225			
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Bel Air Mem. Gardens		Date 2/11/2004		20c. Location - City or Town, State Bel Air, Maryland
	21. Signature of Funeral Service Licensee <i>Donna M. Brzezinski</i>			22. Name and Address of Facility Gonce Funeral Service, P.A. 4001 Ritchie Highway Baltimore, Maryland 21225			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Congestive Heart Failure Coronary Artery Disease Approximate Interval Between Onset and Death 1 year 20 years						
23b. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown 23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <input type="checkbox"/> Unknown 23d. Date of delivery Month Day Year							
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Atrial fibrillation, Chronic Obstructive Pulmonary Disease							
23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Probably <input type="checkbox"/> Unknown							
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No							
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No							
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No							
26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide							
28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No 28d. Describe how injury occurred 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)							
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.							
29b. Signature and title of certifier <i>Alan N. Seunig</i>							
29c. License number D30555							
29d. Date signed (Month, Day, Year) February 9, 2004							
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Alan N. Seunig 901 East Fort Avenue, Baltimore MD 21230							
31. Date filed (Month, Day, Year) FEB 10 2004							
32. Registrar's Signature <i>John B. [Signature]</i>							

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial/transit permit.

To Be Completed by Physician/Medical Examiner

State
Registrar

1- For State Registrar

Unpend Item #23a, 27, 28a-f per mr G828 2/25/04

Certificate of Death

Reg. No.

2004 03766

3133

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760, PG. #5

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

1. Decedent's Name (First, Middle, Last) LATASHA NICOLE ANDERSON		2. Date of Death Month Day Year JANUARY 22, 2004		3. Time of Death Hour Minute AM/PM 0956 A M	
4a. Facility Name (If not institution, give street and number) PRINCE GEORGES HOSPITAL CENTER		4b. City, Town, or Location of Death CHEVERLY		4c. County of Death PRINCE GEORGES	
5. Social Security Number	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) Yrs.	8. Date of Birth (Month, Day, Year) Months Days Hours Min. 4 26	9. Birthplace (State or Foreign Country) AUG. 27, 2003 WASHINGTON, DC	
Usual Residence of Decedent					
10a. State DC	10b. County	10c. City, Town or Location WASHINGTON		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
10e. Street and Number 3224 E ST. SE #4		10f. Zip Code 20019		10g. Citizen of What Country? UNITED STATES	
11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:	
14. Race - American Indian, Black, White, etc. Specify: BLACK		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 0 College (1-4 or 5+) N/A			
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)		16b. Kind of Business/Industry			
17. Father's Name (First, Middle, Last) RICO GLADNEY		18. Mother's Name (First, Middle, Maiden Surname) LAKESHA ANDERSON			
19a. Informant's Name/Relationship (Type, Print) LAKESHA ANDERSON / MOTHER		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3224 E ST. SE #4 WASHINGTON, DC 20019			
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) WASHINGTON NAT. CEM.		20c. Location - City or Town, State 03 FEB 2004 SUITLAND, MD	
21. Signature of Funeral Service Licensee 		22. Name and Address of Facility MARSHALL'S FUNERAL HOME OF MARYLAND, INC. 4308 SUITLAND ROAD SUITLAND, MD 20746			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. SUDDEN UNEXPLAINED DEATH IN INFANCY					
23b. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.					
23c. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown					
24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No					
24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No					
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input checked="" type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input checked="" type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year) FOUND 1/22/04		28b. Time of Injury 8:50 A M	
28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred UNKNOWN			
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) FOUND IN DWELLING		28f. Location (Street and Number or Rural Route Number, City or Town, State) 329 ANACOSTIA RD., APT. L31, WASHINGTON, D.C.			
29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.					
29b. Signature and title of certifier 		29c. License number OCME		29d. Date signed (Month, Day, Year) JANUARY 23, 2004	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) LING LI, M.D. 111 Penn Street, Baltimore, Maryland 21201					
31. Date filed (Month, Day, Year) JAN 30 2004		32. Registrar's Signature 			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2004 03767

1- For
State
RegistrarPhysician
/Medical
ExaminerFuneral
Director

1. Decedent's Name (First, Middle, Last) Edna Wade Allen				2. Date of Death Month Day Year January 14, 2004		3. Time of Death 11:26pm	
4a. Facility Name (If not institution, give street and number) Washington Adventist Hosp				4b. City, Town, or Location of Death Takoma Park		4c. County of Death Prince Georges	
5. Social Security Number 578-54-7676		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 67 Yrs.		8. Date of Birth (Month, Day, Year) Dec 1, 1936	
9. Birthplace (State or Foreign Country) Halifax, CO, NC							
10a. State Dc		10b. County		10c. City, Town or Location Washington DC		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
10e. Street and Number 2425 Alabama Ave				10f. Zip Code 20020		10g. Citizen of What Country? United States	
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: Black	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Switchboard Operator		16b. Kind of Business/Industry Private	
17. Father's Name (First, Middle, Last) John Richard Edmonds				18. Mother's Name (First, Middle, Maiden Surname) Geneva Wade			
19a. Informant's Name/Relationship (Type, Print) Jerry S. Allen Sr. /Son				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 907 Michele Ct., Landover, MD 20785			
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Harmony Memorial Park		20c. Date 1-23-04		20d. Location - City or Town, State Landover, MD	
21. Signature of Funeral Service Licensee <i>Debra M. Davis</i>				22. Name and Address of Facility Alexander S. Pope Funeral Home 2617 Penn. Ave S.E. Washington DC 20020			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. End Stage Dilated Cardiomyopathy Due to (or as a consequence of): b. Ischemic Heart Disease Due to (or as a consequence of): c. Due to (or as a consequence of): d. Approximate Interval Between Onset and Death 3 years 20 years							
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No 9 Unknown				23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Unknown		23d. Date of delivery Month Day Year	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Chronic obstructive Lung Disease				23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown			
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
28d. Describe how injury occurred				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			
28f. Location (Street and Number or Rural Route Number, City or Town, State)							
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. Signature and title of certifier <i>Dr. Srividhar Chatrathi</i>		29c. License number 52119	
				29d. Date signed (Month, Day, Year) 1-15-04			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DR. SRIVIDHAR CHATRATHI 8100 Good Luck Rd. LANHAM, Md. 20706							
31. Date filed (Month, Day, Year) JAN 21 2004				32. Registrar's Signature <i>John K. Smith</i>			

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

State
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2004 03768

1- For
State
RegistrarPhysician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

MARGIE FREEMAN ANDERSON

2. Date of Death

JAN 16, 2004

3. Time of Death

7:07P^M

4a. Facility Name (If not institution, give street and number)

Civista Medical Center

4b. City, Town, or Location of Death

LaPlata

4c. County of Death

Charles

Funeral
Director

5. Social Security Number

578 54 0464

6. Sex

☐ M ☒ F

7. Age (In yrs. last birthday)

64 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

SEPT. 06, 1939

9. Birthplace (State or Foreign Country)

NORTH CAROLINA

Usual Residence of Decedent

10a. State

MARYLAND

10b. County

CHARLES

10c. City, Town or Location

INDIAN HEAD

10d. Inside City Limits

☒ Yes ☐ No

10e. Street and Number

25 RIVERSIDE RUN DRIVE

10f. Zip Code

20640

10g. Citizen of What Country?

UNITED STATES

11. Marital Status

☐ Never Married ☐ Married☒ Widowed ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

☐ Yes ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

☐ Yes ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: BLACK

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12TH

College (1-4or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

SECRETARY

16b. Kind of Business/Industry

NASA

17. Father's Name (First, Middle, Last)

JAMES FREEMAN

18. Mother's Name (First, Middle, Maiden Surname)

MARY WILLIAMS

19a. Informant's Name/Relationship (Type, Print)

ROBIN ANDERSON / DAUGHTER

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

25 RIVERSIDE RUN DRIVE INDIAN HEAD, MD 20640

20a. Method of Disposition

☒ Burial ☐ Cremation ☐ Removal from State☐ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

HARMONY MEMORIAL PK. JAN. 23, 04 LARGO, MARYLAND

Date

20c. Location - City or Town, State

21. Signature of Funeral/Service Licensee



22. Name and Address of Facility

MARSHALL'S FUNERAL HOME OF MARYLAND, INC.
4308 SUITLAND ROAD SUITLAND, MD 20746

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Renal cell carcinoma with metastasis
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

☐ Yes ☒ No ☐ Unknown

23c. If yes, outcome of pregnancy

☐ Live birth ☐ Fetal death ☐ Ectopic pregnancy☐ Pregnant at time of death ☐ Other (Specify)☐ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

☐ Yes ☒ No ☐ Probably ☐ Unknown

24a. Was an autopsy performed?

☐ Yes ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

☐ Yes ☒ No

25. Was case referred to medical examiner?

☐ Yes ☒ No

Hospital:

☒ Inpatient☐ ER/Outpatient ☐ DOA

Other:

☐ Nursing Home ☐ Residence ☐ Other (Specify)

27. Manner of Death

☒ Natural☐ Accident☐ Suicide☐ Homicide☐ Pending investigation☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work? ☐ Yes ☒ No

28d. Describe how injury occurred

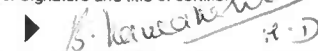
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier



29c. License number

D-0056949

29d. Date signed (Month, Day, Year)

1/17/04

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Kamakshi Baig MD 6620 Crain Hwy Ste 102 LaPlata, MD 20646

31. Date filed (Month, Day, Year)

JAN 21 2004

32. Registrar's Signature

State
RegistrarMarge Anderson
Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

CR (3)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

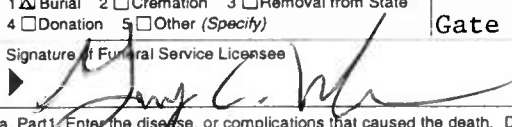
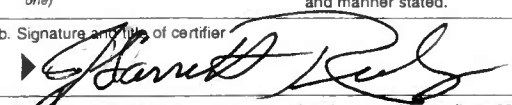
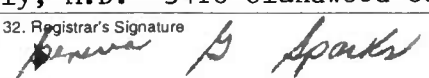
State of Maryland / Department of Health and Mental Hygiene

2004 03769

1- For
State
Registrar

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Mary Alice Austen				2. Date of Death Month January Day 19 Year 2004				3. Time of Death 1:30 AM	
	4a. Facility Name (If not institution, give street and number) Montgomery General Hospital				4b. City, Town, or Location of Death Olney				4c. County of Death Montgomery	
Funeral Director	5. Social Security Number 088-07-8930		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 88 Yrs.		8. Date of Birth (Month, Day, Year) May 25, 1915		9. Birthplace (State or Foreign Country) New Jersey	
	10a. State Maryland		10b. County Montgomery		10c. City, Town or Location North Potomac		10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			
To Be Completed by Funeral Director	10e. Street and Number 14440 Rich Branch Drive				10f. Zip Code 20878		10g. Citizen of What Country? United States			
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 2		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Mother			16b. Kind of Business/Industry Home				
	17. Father's Name (First, Middle, Last) Robert Way				18. Mother's Name (First, Middle, Maiden Surname) Mary McDonnell					
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) Robert T. Austen / Son				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 14440 Rich Branch Dr. North Potomac, MD 20878					
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Gate of Heaven Cem.		Date Jan. 21, 2004		20c. Location - City or Town, State Silver Spring, MD			
	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility DeVol Funeral Home 10 E. Deer Park Dr. Gaithersburg, MD 20877					
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) ischemic bowel Due to (or as a consequence of): Diabetes Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Arthrosclerotic vascular disease Due to (or as a consequence of): Hypertension									
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 9 <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 4 <input type="checkbox"/> Pregnant at time of death 9 <input type="checkbox"/> Unknown				3 <input type="checkbox"/> Ectopic pregnancy 5 <input type="checkbox"/> Other (specify)		23d. Date of delivery Month Day Year		
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown		
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No								
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA		26. Place of Death (Check only one) Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)						
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred		
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)						
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.										
29b. Signature and Title of certifier 				29c. License number D39190		29d. Date signed (Month, Day, Year) January 19, 2004				
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Joseph Garrett Reilly, M.D. 3418 Olandwood Court #111 Olney, Maryland 20832										
31. Date filed (Month, Day, Year) JAN 20 2004		32. Registrar's Signature 								

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

State
Registrar

DHMH 17 Rev 1/2001

ORIGINAL

2004 03770

DHMH 17 Rev 1/2001

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

1- For State Registrar

2004 03771

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

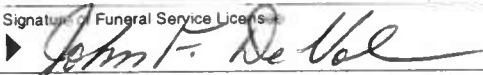
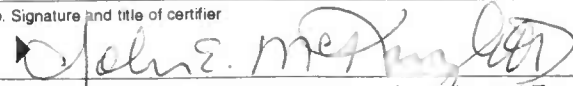

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Physician /Medical Examiner

Funeral Director

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

1. Decedent's Name (First, Middle, Last) Donald L. Anderson				2. Date of Death Month January Day 17 , Year 2004		3. Time of Death 10:50 P.M.	
4a. Facility Name (If not institution, give street and number) Layhill Center				4b. City, Town, or Location of Death Silver Spring		4c. County of Death Montgomery	
5. Social Security Number 368-32-8308		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 71 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) April 2, 1932	9. Birthplace (State or Foreign Country) Pennsylvania
Usual Residence of Decedent							
10a. State D.C.		10b. County None		10c. City, Town or Location Washington		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
10e. Street and Number 712 A 3rd Street S.W.				10f. Zip Code 20024		10g. Citizen of What Country? U.S.A	
11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: 1953-55		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: Black	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 5+ College (1-4or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Lawyer		16b. Kind of Business/Industry National Community Dev. Organization	
17. Father's Name (First, Middle, Last) Russell Lloyd Anderson, Sr.				18. Mother's Name (First, Middle, Maiden Surname) Celeste Johnson			
19a. Informant's Name/Relationship (Type, Print) Dolores L. Farr / Sister				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4022 Wexford Drive Kensington, Maryland 20895			
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Daniel's Mountain Cem.		Date Jan. 24,		20c. Location - City or Town, State Botetourt, Virginia	
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility DeVol Funeral Home 2222 Wisconsin Ave. N.W. Washington, D.C. 20007			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Metastatic Lung Cancer Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d.							Approximate Interval Between Onset and Death 8 Months
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Unknown <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Other (specify)		23d. Date of delivery Month Day Year			
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23e. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown	
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28d. Describe how injury occurred			
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier 		29c. License number 15185		29d. Date signed (Month, Day, Year) January 20, 2004	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) John E. McKnight, M.D. 106 Irving Street, N.W. Washington, D.C. 20010							
31. Date filed (Month, Day, Year) JAN 21 2004				32. Registrar's Signature 			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2004 03772

Certificate of Death

Reg. No.

1- For
State
RegistrarPhysician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Robert R. Akins

2. Date of Death

January 15, 2004

3. Time of Death

4:19 PM

Funeral
Director

4a. Facility Name (If not institution, give street and number)

Suburban Hospital

4b. City, Town, or Location of Death

Bethesda

4c. County of Death

Montgomery

5. Social Security Number

217-52-2969

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

55 Yrs.

If Under 1 Year

Months

If Under 24 Hrs.

Hours

8. Date of Birth

June 17, 1948

9. Birthplace (State or Foreign Country)

Florida

Usual Residence of Decedent

10a. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Rockville

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

332 Howard Avenue

10f. Zip Code

20850

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

1 ☒ Yes 2 ☐ No
If Yes, Give Year or Dates: Vietnam13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: White

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

3

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Owner

16b. Kind of Business/Industry

Electrician

17. Father's Name (First, Middle, Last)

Vernon R. Akins

18. Mother's Name (First, Middle, Maiden Sumame)

Eudalia Graham

19a. Informant's Name/Relationship (Type, Print)

Patricia M. Akins/Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

332 Howard Avenue, Rockville, Maryland 20850

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)Montgomery
Crematorium, Inc.

Date

January 21,
2004

20c. Location - City or Town, State

Bethesda, Maryland

21. Signature of Funeral Service Licensee

M01346

22. Name and Address of Facility

Robert A. Pumphrey Funeral Home/
Rockville, Inc. 300 West Montgomery Avenue
Rockville, Maryland 20850-280523a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

a. Arrhythmia

Approximate
Interval Between
Onset and Death

1 Hour

Due to (or as a consequence of):

b. Coronary Artery Disease

5 Years

Due to (or as a consequence of):

c. Hypertension

10 Years

Due to (or as a consequence of):

d. Diabetic Nephropathy on Hemodialysis

5 Years

IF FEMALE:

23b. Was decedent pregnant
in the past 12 months?
1 ☐ Yes 2 ☐ No
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy
4 ☐ Pregnant at time of death 5 ☐ Other (specify)
9 ☐ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Anemia

Hypothyroidism

History of Chronic Heart Failure, Diabetic Retinopathy

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☒ Probably 4 ☐ Unknown24a. Was an
autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings available
prior to completion of cause of
death?1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?1 ☒ Yes 2 ☐ No

Hospital:

1 ☐ Inpatient 2 ☒ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending
2 ☐ Accident investigation
3 ☐ Suicide 6 ☐ Could not be
4 ☐ Homicide determined

28a. Date of Injury

(Month, Day Year)

28b. Time of
Injury

M

28c. Injury at
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
and manner stated.

29b. Signature and title of certifier

29c. License number

D23091

29d. Date signed (Month, Day, Year)

01/16/04

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Kaldun NOSSULI 4915 Auburn Av-Bethesda MD 20814

31. Date filed (Month, Day, Year)

JAN 22 2004

32. Registrar's Signature

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23e or 28a-f show
any injury or other traumatic event, the Medical Examiner must be notified at
once.To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.


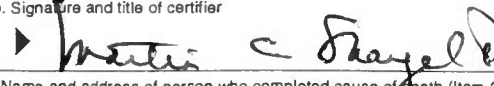
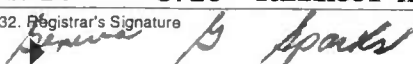
State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2004 03773

1- For
State
Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) JOHN EDWARD ADAMS				2. Date of Death Month JAN. Day 16, Year 2004		3. Time of Death 1:03 P^M		
	4a. Facility Name (If not institution, give street and number) RANDOLPH HILLS NURSING HOME				4b. City, Town, or Location of Death WHEATON		4c. County of Death MONTGOMERY		
Funeral Director	5. Social Security Number 215-38-3067		6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		7. Age (In yrs. last birthday) 63 Yrs.		8. Date of Birth (Month, Day, Year) JULY 4, 1940		
	9. Birthplace (State or Foreign Country) DELAWARE		10a. State MD.		10b. County MONTGOMERY		10c. City, Town or Location WHEATON		
Usual Residence of Decedent		10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		10e. Street and Number 4011 RANDOLPH RD.		10f. Zip Code 20912		10g. Citizen of What Country? U.S.A.	
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates VIETNAM		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: WHITE			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 9 College (1-4 or 5+) CAB DRIVER		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) CAB DRIVER		16b. Kind of Business/Industry TRANSPORTATION					
17. Father's Name (First, Middle, Last) EDWARD THOMPSON ADAMS				18. Mother's Name (First, Middle, Maiden Surname) MABEL ETHEL HAGER					
19a. Informant's Name/Relationship (Type, Print) JEANNE HALTIWANGER/SISTER				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6911 CARLETON TERR., COLLEGE PARK, MD. 20740					
20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) CHAMBERS CREMATORY		Date 1-21-2004		20c. Location - City or Town, State RIVERDALE, MD.			
21. Signature of Funeral Service Licensee 		M00091		22. Name and Address of Facility CHAMBERS FUNERAL HOME & CREMATORIUM, P.A. 5801 CLEVELAND AVE., RIVERDALE, MD. 20737					
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. SEPTICEMIA Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d.		23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify)		23d. Date of delivery Month Day Year		Approximate Interval Between Onset and Death week	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. PNEUMONIA, DEHYDRATION				23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown		24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M	
28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier 		29c. License number D08944		29d. Date signed (Month, Day, Year) JAN. 20, 2004			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MARTIN SHARGEL, M.D. 3720 FARRAGUT AVE., KENSINGTON, MD. 20895		31. Date filed (Month, Day, Year) JAN 22 2004		32. Registrar's Signature 					

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification; To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2004 03774

1- For
State
RegistrarPhysician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

DAVID ABRAHAM ABEL

2. Date of Death
Month Day Year

JANUARY 13, 2004

3. Time of Death

1920 M

Funeral
Director

4a. Facility Name (If not institution, give street and number)

OLDGROVE REHABILITATION AND NURSING

4b. City, Town, or Location of Death

SANDY SPRING

4c. County of Death

MONTGOMERY

5. Social Security Number

010-05-0577

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

85

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth
(Month, Day, Year)

Jan. 19, 1918

9. Birthplace (State or Foreign
Country)

Massachusetts

Usual Residence of Decedent

10a. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Silver Spring

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

15100 Interlachen Drive, #817

10f. Zip Code

20906

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced12. Was Decedent Ever in U.S.
Armed Forces?1 ☒ Yes 2 ☐ No
If Yes, Give
Year or Dates: WWII13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: White

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

5+

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Attorney

16b. Kind of Business/Industry

Law

17. Father's Name (First, Middle, Last)

Joseph Abel

18. Mother's Name (First, Middle, Maiden Surname)

Ida Yaffi

19a. Informant's Name/Relationship (Type, Print)

June Abel, Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

15100 Interlachen Dr., #817 Silver Spring, MD 20906

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Judean Memorial Garden 1/15/04

Date

20c. Location - City or Town, State

Olney, Maryland

21. Signature of Funeral Service Licensee

[Signature]

22. Name and Address of Facility

Edward Sagel Funeral Direction, Inc.
1091 Rockville Pike, Rockville, MD 2085223a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

a. ASPIRATION PNEUMONIA

Due to (or as a consequence of):

b. DYSPHAGIA

Due to (or as a consequence of):

c. VASCULAR DEMENTIA

Due to (or as a consequence of):

d.

Approximate
Interval Between
Onset and Death

DAYS

MONTHS

YEARS

IF FEMALE:

23b. Was decedent pregnant
in the past 12 months?1 ☐ Yes 2 ☐ No
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy
4 ☐ Pregnant at time of death 5 ☐ Other (specify)
9 ☐ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

DIABETES MELLITUS

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an
autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings available
prior to completion of cause of
death?1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending
Investigation
6 ☐ Could not be
determined28a. Date of Injury
(Month, Day, Year)28b. Time of
Injury

M

28c. Injury at
Work?1 ☐ Yes 2 ☐ No28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)2 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
and manner stated.

29b. Signature and title of certifier

[Signature] ATTENDING PHYSICIAN

29c. License number

D42046

29d. Date signed (Month, Day, Year)

JANUARY 14, 2004

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

GRACE BROCKHUFFMAN, M.D. 18100 SLADE SCHOOL ROAD SANDY SPRING, MARYLAND 20860

31. Date filed (Month, Day, Year)

JAN 20 2004

32. Registrar's Signature

[Signature]

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show
any injury or other traumatic event, the Medical Examiner must be notified at
once.To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2004 03775

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Alice Abdow

2. Date of Death
Month Day Year

Jan. 14, 2004

3. Time of Death

6:30pm

4e. Facility Name (If not institution, give street and number)

Manor Care Bethesda

4b. City, Town, or Location of Death

Bethesda

4c. County of Death

Montgomery

Funeral
Director

5. Social Security Number

027-09-2872

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

92

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth
(Month, Day, Year)

11/10/1911

9. Birthplace (State or Foreign Country)

Worcester, MA

Usual Residence of Decedent

10a. State

Md

10b. County

Montgomery

10c. City, Town or Location

Bethesda

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

6530 Democracy Blvd.

10f. Zip Code

2-817

10g. Citizen of What Country?

USA

11. Marital Status

1 ☒ Never Married 2 ☐ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: White

15. Decedent's Education
(Specify only highest grade completed)Elementary/Secondary (0-12)
12

College (1-4 or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Self Employed

16b. Kind of Business/Industry

Photography

17. Father's Name (First, Middle, Last)

Francis Abdow

18. Mother's Name (First, Middle, Maiden Surname)

Besma Abdow

19a. Informant's Name/Relationship (Type, Print)

Mark Abdow/Nephew

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

9425 Spruce Tree Circle Bethesda, Md 20814

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Gate of Heaven

Date

1/20/04

20c. Location - City or Town, State

Silver Spring, Md

21. Signature of Funeral Service Licensee

Philip D. Rinaldi

22. Name and Address of Facility

PHILIP D. RINALDI FUNERAL SERVICE, P.A.
9241 Columbia Blvd Silver Spring, Md 2091023a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Approximate
Interval Between
Onset and DeathImmediate Cause (Final
disease or condition
resulting in death)

a. Urosepsis

Due to (or as a consequence of):

b. Pre-renal azotemia

Due to (or as a consequence of):

c. Alzheimer's disease

Due to (or as a consequence of):

d. Atrial fibrillation

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

hypertension

diabetes mellitus

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation
6 ☐ Could not be determined28a. Date of Injury
(Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Kirti Vohra MD

29c. License number

D20274

29d. Date signed (Month, Day, Year)

Jan. 14, 2004

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Kirti Vohra MD 7710 Bradley Blvd. Bethesda, Md 20817

31. Date filed (Month, Day, Year)

JAN 21 2004

32. Registrar's Signature

Benita Sparks

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show
any injury or other traumatic event, the Medical Examiner must be notified at
once.Physician
/Medical
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2004 03776

1- For State Registrar

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial/transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

Funeral Director

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

1. Decedent's Name (First, Middle, Last) Lewis Dale Barton				2. Date of Death Month January Day 20 Year 2004		3. Time of Death 12:45A M	
4a. Facility Name (If not institution, give street and number) 3911 York Lane				4b. City, Town, or Location of Death Bowie		4c. County of Death Prince George's	
5. Social Security Number 486-12-1909		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 86 Yrs.		8. Date of Birth (Month, Day, Year) June 19, 1917	
9. Birthplace (State or Foreign Country) Missouri							
Usual Residence of Decedent							
10a. State MD		10b. County Prince George's		10c. City, Town or Location Bowie		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
10e. Street and Number 3911 York Lane				10f. Zip Code 20715		10g. Citizen of What Country? USA	
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: WW II		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 4 College (1-4or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) District Director		16b. Kind of Business/Industry U.S. Government	
17. Father's Name (First, Middle, Last) Morris D. Barton				18. Mother's Name (First, Middle, Maiden Surname) Dovie M. Richardson			
19a. Informant's Name/Relationship (Type, Print) Jacqueline Byrd / Pers. Rep.				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 14300 Gallant Fox Lane Suite 120 Bowie, MD. 20715			
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Lakemont Mem. Gardens		Date 1-22-2004		20c. Location - City or Town, State Davidsonville, MD.	
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility Beall Funeral Home 6512 NW Crain Highway Bowie, MD. 20715			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Pneumonia Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last							
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify)				23d. Date of delivery Month Day Year	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Coronary Artery Disease Chronis Obstructive Pulmonary Disease						23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Probably <input type="checkbox"/> Unknown	
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No					
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28d. Describe how injury occurred			
28f. Location (Street and Number or Rural Route Number, City or Town, State)							
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.							
29b. Signature and title of certifier  MD				29c. License number DS0343		29d. Date signed (Month, Day, Year) January 22, 2004	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Kelvin Hao, M.D. 14999 Health Center Dr. Suite 201 Bowie, MD. 20716							
31. Date filed (Month, Day, Year) JAN 22 2004				32. Registrar's Signature 			

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
 Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
 To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

1. Decedent's Name (First, Middle, Last) MARGARET BUZY MARGARET P. BUZY		2. Date of Death Month Day Year JAN 19 2004		3. Time of Death 10:34 AM	
4a. Facility Name (If not institution, give street and number) Suburban Hospital		4b. City, Town, or Location of Death Bethesda		4c. County of Death Montgomery	
5. Social Security Number 058-26-7803		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 72 Yrs.	
8. Date of Birth (Month, Day, Year) Aug. 23, 1931		9. Birthplace (State or Foreign Country) New York			
Usual Residence of Decedent					
10a. State Maryland		10b. County Montgomery		10c. City, Town or Location Rockville	
10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No					
10e. Street and Number 11709 Stonewood Lane		10f. Zip Code 20852		10g. Citizen of What Country? USA	
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:	
14. Race - American Indian, Black, White, etc. Specify: White					
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 2		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Nurse Massage Therapist		16b. Kind of Business/Industry Health Care	
17. Father's Name (First, Middle, Last) Patrick Healy		18. Mother's Name (First, Middle, Maiden Surname) Margaret Tracy			
19a. Informant's Name/Relationship (Type, Print) Joseph Buzy/ Husband		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11709 Stonewood Lane, Rockville, MD 20852			
20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Metropolitan Crematory		20c. Location - City or Town, State Alexandria, Virginia	
21. Signature of Funeral Service Licensee 		22. Name and Address of Facility Francis J. Collins Funeral Home Inc. 500 University Blvd. W., Silver Spring, MD 2090			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. MULTIPLE MYELOMA Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last					
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 9 <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) 9 <input type="checkbox"/> Unknown		23d. Date of delivery Month Day Year	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Auto Renal Failure Pneumonia					
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No			
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> OOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M	
28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred			
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.					
29b. Signature and title of certifier 		29c. License number D29675		29d. Date signed (Month, Day, Year) JAN 20 2004	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Randy Boccia MD 0420 Rockledge Dr Bethesda, MD					
31. Date filed (Month, Day, Year) JAN 22 2004		32. Registrar's Signature 			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2004 03778

1- For
State
RegistrarPhysician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Elizabeth Mish Butler

2. Date of Death
Month Day Year
Jan. 4, 20043. Time of Death
6:55A MFuneral
Director

4a. Facility Name (If not institution, give street and number)

Washington Adventist Hospital

4b. City, Town, or Location of Death

Takoma Park

4c. County of Death

Montgomery

5. Social Security Number
447-22-56146. Sex
1 ☐ M 2 ☒ F7. Age (In yrs. last birthday)
88 Yrs.If Under 1 Year
Months DaysIf Under 24 Hrs.
Hours Min.8. Date of Birth
(Month, Day, Year)
Jan. 29, 19159. Birthplace (State or Foreign
Country)
Virginia

Usual Residence of Decedent

10a. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Silver Spring

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

9201 Wire Aveune

10f. Zip Code

20910

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☐ Widowed 4 ☒ Divorced12. Was Decedent Ever in U.S.
Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.
Specify: White15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4or 5+)

4

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Librarian

16b. Kind of Business/Industry

Public School System

17. Father's Name (First, Middle, Last)

William Graham Mish

18. Mother's Name (First, Middle, Maiden Surname)

Edna Irving Cleaver

19a. Informant's Name/Relationship (Type, Print)

Graham M. Butler (Son)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2499 Rice St., #125, Roseville, MN 55113

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)
Bethel Presbyterian
Church Cemetery

Date

January 12
2004

20c. Location - City or Town, State

Staunton, VA

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Rapp Funeral And Cremation Services
933 Gist Ave., Silver Spring, MD 2091023a. Part I. Enter the disease, or complication, that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

a. Ischemic Cardiomyopathy

Due to (or as a consequence of):

b. Coronary Artery Disease

Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate
Interval Between
Onset and Death

IF FEMALE:

23b. Was decedent pregnant
in the past 12 months?
1 ☐ Yes 2 ☒ No
9 ☐ Unknown23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown3 ☐ Ectopic pregnancy
5 ☐ Other (specify)23d. Date of delivery
Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Metastatic Malignancy in liver

Primary Unknown

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an
autopsy
performed?
1 ☒ Yes 2 ☐ No24b. Were autopsy findings available
prior to completion of cause of
death?
1 ☒ Yes 2 ☐ No25. Was case referred to medical
examiner?
1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending
investigation
2 ☐ Accident 6 ☐ Could not be
determined
3 ☐ Suicide 4 ☐ Homicide28a. Date of Injury
(Month, Day Year)28b. Time of
Injury
M28c. Injury at
Work?
1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
and manner stated.

29b. Signature and title of certifier

29c. License number
D2039129d. Date signed (Month, Day, Year)
1-21-04

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Jeffrey A. Kelman M.D. 6525 Belcrest Road Hyattsville, MD 20782

State
Registrar

31. Date filed (Month, Day, Year)

JAN 23 2004

32. Registrar's Signature

Benjamin S Sparks

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural," or items 23a or 28e-f show
any injury or other traumatic event, the Medical Examiner must be notified at
once.Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

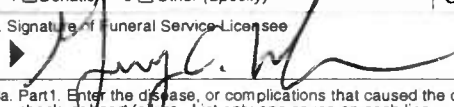
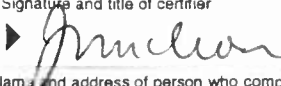

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

1- For
State
Registrar

2004 03779

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Don F. Bredice				2. Date of Death Month January Day 13 Year 2004		3. Time of Death 4:26 P M	
	4a. Facility Name (If not institution, give street and number) Shady Grove Adventist Hospital				4b. City, Town, or Location of Death Rockville		4c. County of Death Montgomery	
Funeral Director	5. Social Security Number 579-16-6658		6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		7. Age (In yrs. last birthday) 85 Yrs.		8. Date of Birth (Month, Day, Year) Oct. 2, 1918	
	9. Birthplace (State or Foreign Country) Washington, DC		10a. State Maryland		10b. County Montgomery		10c. City, Town or Location Gaithersburg	
To Be Completed by Funeral Director	10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		10e. Street and Number 9614 Duffer Way		10f. Zip Code 20879		10g. Citizen of What Country? United States	
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Shoemaker		16b. Kind of Business/Industry Self Employed			
	17. Father's Name (First, Middle, Last) Francesco Bredice				18. Mother's Name (First, Middle, Maiden Surname) Michela Pirrone			
	19a. Informant's Name/Relationship (Type, Print) Daniel Bredice / Son				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20302 Brook Run Place Germantown, MD 20876			
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Columbia Gardens		Date Jan. 17, 2004		20c. Location - City or Town, State Arlington, Virginia	
	21. Signature of Funeral Service Licensee 		22. Name and Address of Facility DeVol Funeral Home 10 E. Deer Park Dr. Gaithersburg, MD 20877					
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Cardiac Arrest Due to (or as a consequence of): b. Pneumonia Due to (or as a consequence of): c. Due to (or as a consequence of): d. Approximate Interval Between Onset and Death 4 Days							
	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Unknown 23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) 9 <input type="checkbox"/> Unknown 23d. Date of delivery Month Day Year							
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Atrial Fibrillation 23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown 24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No							
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) 26. Place of Death (Check only one) 27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury M 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 28d. Describe how injury occurred 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)								
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier  29c. License number D 051714 29d. Date signed (Month, Day, Year) January 13, 2004								
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Jatinder Singh Sekhon, M.D. 2401 Research Blvd. #102 Rockville, Maryland 20850								
31. Date filed (Month, Day, Year) JAN 20 2004		32. Registrar's Signature 						

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury greater traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2004 03780

1- State Registrar

Physician
/Medical
ExaminerFuneral
Director

To Be Completed by Funeral Director

1. Decedent's Name (First, Middle, Last) Allen Berlinsky				2. Date of Death Month Day Year January 9, 2004		3. Time of Death 12:45 A M	
4a. Facility Name (If not institution, give street and number) Hebrew Home of Greater Washington				4b. City, Town, or Location of Death Rockville		4c. County of Death Montgomery	
5. Social Security Number 579-16-4739		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 95 Yrs.		8. Date of Birth (Month, Day, Year) Aug 29, 1908	
9. Birthplace (State or Foreign Country) Washington, DC		Usual Residence of Decedent					
10a. State DC		10b. County None		10c. City, Town or Location Washington		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
10e. Street and Number 4101 Cathedral Avenue, NW #910				10f. Zip Code 20016		10g. Citizen of What Country? United States	
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: white	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 9 College (1-4or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Transportation Specialist		16b. Kind of Business/Industry U.S. Navy Department	
17. Father's Name (First, Middle, Last) Max Berlinsky				18. Mother's Name (First, Middle, Maiden Surname) Sophie "Unknown"			
19a. Informant's Name/Relationship (Type, Print) Jeanne M. Berlinsky, wife				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4101 Cathedral Avenue, NW #910 Washington, DC 20016			
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Judean Memorial Garden 1/11/04		20c. Location - City or Town, State Olney, Maryland		20d. Date 1/11/04	
21. Signature of Funeral Service Licensee <i>[Signature]</i>				22. Name and Address of Facility Danzansky-Goldberg Memorial Chapels, Inc. 1170 Rockville Pike, Rockville, MD 20852			

Physician
/Medical
Examiner

To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. <i>Urosepsis</i> Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last				Approximate Interval Between Onset and Death			
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <input type="checkbox"/> Unknown		23d. Date of delivery Month Day Year			
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown	
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. Signature and title of certifier <i>[Signature]</i> M.D.				29c. License number D 55258		29d. Date signed (Month, Day, Year) January 9, 2004	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Gary B. Wilk, MD 6121 MONTROSS ROAD ROCKVILLE MARYLAND 20852							
31. Date filed (Month, Day, Year) JAN 20 2004				32. Registrar's Signature <i>[Signature]</i>			

State
Registrar

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2004 03781

1- For
State
RegistrarPhysician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Walter William Brandt

2. Date of Death

January 16, 2004

3. Time of Death

5:10 a M

Funeral
Director

4a. Facility Name (If not institution, give street and number)

Hillhaven Nursing Center Inc.

4b. City, Town, or Location of Death

Adelphi

4c. County of Death

Prince George's

5. Social Security Number

578-10-0116

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

93 Yrs.

If Under 1 Year

Months Days Hours Min.

8. Date of Birth (Month, Day, Year)

Oct. 26, 1910

9. Birthplace (State or Foreign Country)

Virginia

Usual Residence of Decedent

10a. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Silver Spring

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

1415 Stateside Drive

10f. Zip Code

20903

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☒ Yes 2 ☐ No
If Yes, Give Year or Dates: WWII

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)
12

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Chief Inspector

16b. Kind of Business/Industry

Municipal Alcohol Control Board

17. Father's Name (First, Middle, Last)

George Gerhardt Brandt

18. Mother's Name (First, Middle, Maiden Surname)

Amelia Barbara Kratz

19a. Informant's Name/Relationship (Type, Print)

Beverly A. Brandt/ Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1415 Stateside Drive, Silver Spring, MD 20903

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Parklawn Memorial Park

Date

January 20 2004

20c. Location - City or Town, State

Rockville, Maryland

21. Signature of Funeral Service Licensee

John E. Parker

22. Name and Address of Facility

Francis J. Collins Funeral Home Inc.
500 University Blvd. W., Silver Spring, MD 20901

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Dehydration

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Dysphagia

Due to (or as a consequence of):

c. Failure To Thrive

Due to (or as a consequence of):

d. Status Post Hip Replacement

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy
4 ☐ Pregnant at time of death 5 ☐ Other (specify)
9 ☐ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Coronary Artery Disease

Dementia

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy performed?
1 ☐ Yes 2 ☒ No24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No25. Was case referred to medical examiner?
1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death Check on one

Other: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation
2 ☐ Accident 6 ☐ Could not be determined
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?
1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Dorothy Mae Seay

29c. License number

D0053337

29d. Date signed (Month, Day, Year)

January 16, 2004

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Dorothy Mae Seay M.D. 10801 Lockwood Drive, Suite 205, Silver Spring, MD 20901

31. Date filed (Month, Day, Year)

JAN 21 2004

32. Registrar's Signature

Denava Sparks

State
Registrar

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2004 03782

1- For State Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <u>JAN Q. BRAM</u>				2. Date of Death Month <u>01</u> Day <u>16</u> Year <u>2004</u>		3. Time of Death <u>1259 PM</u>	
	4a. Facility Name (If not institution, give street and number) <u>WASHINGTON ADVENTIST HOSPITAL</u>				4b. City, Town, or Location of Death <u>TRACOMA PARK</u>		4c. County of Death <u>MONTGOMERY</u>	
Funeral Director	5. Social Security Number <u>259-40-4746</u>		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <u>72</u> Yrs.	8. Date of Birth (Month, Day, Year) <u>Sept. 23, 1931</u>		9. Birthplace (State or Foreign Country) <u>Georgia</u>	
	Usual Residence of Decedent							
10a. State <u>Maryland</u>		10b. County <u>Montgomery</u>		10c. City, Town or Location <u>Silver Spring</u>		10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
10e. Street and Number <u>1220 East-West Highway #722</u>				10f. Zip Code <u>20910</u>		10g. Citizen of What Country? <u>USA</u>		
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <u>White</u>		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <u>1</u> College (1-4 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <u>Secretary</u>		16b. Kind of Business/Industry <u>U.S. Government</u>		
17. Father's Name (First, Middle, Last) <u>Victor Leontel Quave, Sr.</u>				18. Mother's Name (First, Middle, Maiden Surname) <u>Evelyn Adele Wilson</u>				
19a. Informant's Name/Relationship (Type, Print) <u>James Philip Finn/ Friend</u>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>1220 East-West Highway #722, Silver Spring, MD 20910</u>				
20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <u>Metropolitan Crematory</u>		Date <u>January 17 2004</u>		20c. Location - City or Town, State <u>Alexandria, Virginia</u>		
21. Signature of Funeral Service Licensee <u>[Signature]</u>				22. Name and Address of Facility <u>Francis J. Collins Funeral Home Inc. 500 University Blvd. W., Silver Spring, MD 20901</u>				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. <u>Myocardial Heart Disease</u> Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last								
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 9 <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) 9 <input type="checkbox"/> Unknown				23d. Date of delivery Month <u>01</u> Day <u>16</u> Year <u>2004</u>		
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown		
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)						
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <u>M</u>		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28d. Describe how injury occurred				
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier <u>[Signature]</u>		29c. License number <u>35427</u>		29d. Date signed (Month, Day, Year) <u>01-16-2004</u>		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <u>James J. Collins, 7600 Canoll Ave Tracoma Park, MD</u>								
31. Date filed (Month, Day, Year) <u>JAN 20 2004</u>		32. Registrar's Signature <u>[Signature]</u>						

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2004 03783

1- For
State
Registrar

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) ELEANOR MARIE BRACKNA				2. Date of Death Month Day Year JANUARY 19, 2004		3. Time of Death 2:00 A. M		
	4a. Facility Name (If not institution, give street and number) CASEY HOUSE				4b. City, Town, or Location of Death ROCKVILLE		4c. County of Death MONTGOMERY		
Funeral Director	5. Social Security Number 165-20-9348	6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 81 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) Aug. 16, 1922		9. Birthplace (State or Foreign Country) Pennsylvania	
	Usual Residence of Decedent								
To Be Completed by Funeral Director	10a. State Maryland	10b. County Montgomery	10c. City, Town or Location Silver Spring			10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			
	10e. Street and Number 11621 New Hampshire Avenue, #221			10f. Zip Code 20904		10g. Citizen of What Country? United States			
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 1-4		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Educator		16b. Kind of Business/Industry Public Schools				
To Be Completed by Physician/Medical Examiner	17. Father's Name (First, Middle, Last) Dominick Wyte			18. Mother's Name (First, Middle, Maiden Surname) Marie Rosnick					
	19a. Informant's Name/Relationship (Type, Print) David A. Brackna -son			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 13608 Duhart Road Germantown, Maryland 20874					
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Maryland Veterans Cem.		Date 1/27/2004		20c. Location - City or Town, State Cheltenham, Maryland		
	21. Signature of Funeral Service Licensee 			22. Name and Address of Facility Donald V. Borgwardt Funeral Home, PA. 4400 Powder Mill Rd. Beltsville, Maryland 20705					
Physician /Medical Examiner	23a. Part 1. Enter the disease, or complications that caused the death, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. End Stage Dementia Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last								
	23b. IF FEMALE: Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 9 <input type="checkbox"/> Unknown								
	23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) 9 <input type="checkbox"/> Unknown								
	23d. Date of delivery Month Day Year								
To Be Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown		
							24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
							24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		
To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other (Specify) HOSPICE						
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred
			28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)		
	29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
State Registrar	29b. Signature and title of certifier 		29c. License number D60582		29d. Date signed (Month, Day, Year) January 19, 2004				
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Joyson Karakunnel, M.D. 6001 Muncaster Mill Rd. Rockville, Maryland 20855								
31. Date filed (Month, Day, Year) JAN 21 2004		32. Registrar's Signature 							

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2004 03784

1- For
State
Registrar

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28e-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Physician
/Medical
ExaminerFuneral
Director

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

1. Decedent's Name (First, Middle, Last) Mary Uveges Borosh		2. Date of Death Month Day Year January 20, 2004		3. Time of Death 4:10 A^M	
4a. Facility Name (If not institution, give street and number) Kessler Adventist Rehab. Center		4b. City, Town, or Location of Death Rockville		4c. County of Death Montgomery	
5. Social Security Number 139-12-0708	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 93 Yrs.	8. Date of Birth (Month, Day, Year) Oct. 3, 1910		9. Birthplace (State or Foreign Country) New Jersey
10a. State Md.		10b. County Montgomery		10c. City, Town or Location Rockville	
10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		10e. Street and Number 600A Veirs Mill Road		10f. Zip Code 20852	
10g. Citizen of What Country? United States		11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:	
13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4or 5+)	
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Clerk		16b. Kind of Business/Industry N.J. Motor Vehicle Administration		17. Father's Name (First, Middle, Last) John Uveges	
18. Mother's Name (First, Middle, Maiden Surname) Mary Slabachuk		19a. Informant's Name/Relationship (Type, Print) Elizabeth Klanga (Daughter)		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19828 Bazzellton Pl. Montgomery Village, Md. 20886	
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Our Lady of Lodes		20c. Location - City or Town, State Trenton, N.J.	
21. Signature of Funeral Service Licensee 		22. Name and Address of Facility DeVol Funeral Home 10 East Deer Park Dr. Gaithersburg, Md. 20877			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. aspiration pneumonia b. Acute respiratory failure c. Hypoxia d. Azotemia		23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <input type="checkbox"/> Unknown	
23d. Date of delivery Month Day Year		23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown			
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No			
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M	
28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred			
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier 		29c. License number D41162	
29d. Date signed (Month, Day, Year) January 20 2004		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) V. Ganti 19529 Doctor Drive Germantown MD 20874			
31. Date filed (Month, Day, Year) JAN 23 2004		32. Registrar's Signature 			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2004 03785

1- For
State
RegistrarPhysician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Elizabeth Kunkle Bork

2. Date of Death

January 15, 2004

3. Time of Death

11:45 P M

4a. Facility Name (If not institution, give street and number)

Carriage Hill Nursing Home

4b. City, Town, or Location of Death

Bethesda

4c. County of Death

Montgomery

Funeral
Director

5. Social Security Number

041-58-3252

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

105 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
Nov. 14, 1898

9. Birthplace (State or Foreign Country)

Pennsylvania

Usual Residence of Decedent

10a. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Bethesda

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

5215 West Cedar Lane

10f. Zip Code

20814

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

2

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

School Teacher

16b. Kind of Business/Industry

Pittsburgh Public Schools

17. Father's Name (First, Middle, Last)

Walter Kunkle

18. Mother's Name (First, Middle, Maiden Surname)

Mary Baughman

19a. Informant's Name/Relationship (Type, Print)

Robert Bork / Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

6520 Ridge St. McLean, VA 22101

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Mt. Comfort Crematory

Date

1/17/2004

20c. Location - City or Town, State

Alexandria, VA

21. Signature of Funeral Service Licensee

Michael C. Keen MO1296

22. Name and Address of Facility

Joseph Gawler's Sons, Inc.
5130 Wisconsin Ave., NW, Washington, DC 20016

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Atrial Fibrillation

Approximate Interval Between Onset and Death

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

a. Due to (or as a consequence of):

Congestive Heart Failure

b. Due to (or as a consequence of):

Hypertensive Heart Disease

c. Due to (or as a consequence of):

d.

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown3 ☐ Ectopic pregnancy
5 ☐ Other (Specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy performed?
1 ☐ Yes 2 ☒ No24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No25. Was case referred to medical examiner?
1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation
2 ☐ Accident 6 ☐ Could not be determined
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Thomas V. Joseph

29c. License number

D47330

29d. Date signed (Month, Day, Year)

January 16, 2004

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Thomas V. Joseph, M.D. 50 W. Edmonston Dr., Suite 207, Rockville, MD 20852

State
Registrar

31. Date filed (Month, Day, Year)

JAN 20 2004

32. Registrar's Signature

Jennifer B. Sparks

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State of Maryland / Department of Health and Mental Hygiene

Reg. No. 2004 03786

1. Decedent's Name (First, Middle, Last)	2. Date of Death <div> <div>Day</div> <div>Month</div> <div>Year</div> </div>	3. Time of Death
Vivienne Isabelle Bonnefil	January 13, 2004	6:20 P M

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Deeth
4102 Cleveland St.	Kensington	Montgomery

5. Social Security Number 252-18-0651	6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 84 Yrs.	If Under 1 Year Months Days		If Under 24 Hrs. Hours Min.		8. Date of Birth (Month, Day, Year) May 29, 1919	9. Birthplace (State or Foreign Country) Georgia
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Usual Residence of Decedent			
10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
Maryland	Montgomery	Kensington	

10e. Street and Number 4102 Cleveland St.	10f. Zip Code 20895	10g. Citizen of What Country? U.S.A.
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<p>11. Marital Status</p> <p>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married</p> <p>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced</p>	<p>12. Was Decedent Ever in U.S. Armed Forces?</p> <p>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No World War II</p> <p>If Yes, Give Year or Dates: War II</p>	<p>13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)</p> <p>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No <i>Specify:</i></p>	<p>14. Race - American Indian, Black, White, etc.</p> <p><i>Specify:</i> White</p>
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15. Decedent's Education <i>(Specify only highest grade completed)</i>		16a. Decedent's Usual Occupation <i>(Give kind of work done during most of working life. DO NOT use retired)</i>	16b. Kind of Business/Industry
Elementary/Secondary (0-12) 12	College (1-4 or 5+) 	Homemaker	Own Home

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Sumame)
Edward C. Lambert	Isabelle Allen

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Nicole Lacroix / Daughter	701 Fitzhugh Way, Alexandria, VA 22314

20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)	20b. Place of Disposition (Name of cemetery, crematory or other place) Gate of Heaven Cem.	Date Jan. 17, 2004	20c. Location - City or Town, State Silver Spring, MD
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21. Signature of Funeral Service Licensee  MO1296	22. Name and Address of Facility Joseph Gawler's Sons, Inc. 5130 Wisconsin Ave., NW, Washington, DC 20016
---	--

23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.		Approximate Interval Between Onset and Death
Immediate Cause (Final		
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disease or condition resulting in death)	a.	Aortic Stenosis	
		Due to (or as a consequence of):	

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events)

b. Due to (or as a consequence of):

c.

resulting in death) Last	Due to (or as a consequence of):	
--------------------------	----------------------------------	--

IF FEMALE:		23c. If yes, outcome of pregnancy	23d. Date of delivery
23b. Was incident reported?			

230. Was decedent pregnant in the past 12 months?
 1 ☐ Yes 2 ☒ No
 3 ☐ Unknown

1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy
 4 ☐ Pregnant at time of death 5 ☐ Other (specify) _____

230. Date of delivery
 Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

		1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown			
24a. Was an	24b. Were autopsy findings available				

		autopsy performed?		prior to completion or cause of death?	
		1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
25. Was case referred to medical		26. Place of Death (Check all that apply)			

26. Place of Death (Check only one)

1 ☐ Yes 2 ☒ No

27. Manner of Death

28a. Date of Injury

28b. Time of

28c. Injury at

28d. Describe how injury occurred

29. Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)


1 <input checked="" type="checkbox"/> Natural	5 <input type="checkbox"/> Pending investigation	200. Date of Injury (Month, Day Year)	201. Body Part Injured	202. Was Worker at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	203. Describe how injury occurred
2 <input type="checkbox"/> Accident	6 <input type="checkbox"/> Could not be				
3 <input type="checkbox"/> Suicide					

4 <input type="checkbox"/> Homicide	<input type="checkbox"/> determined	28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)
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29a. Certifier (Check only one)

162 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of carrier 	29c. License number MD 38888	29d. Date signed (Month, Day, Year) 1/15/04
--	---------------------------------	--

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
 Harry J. Richman, Jr. M.D. 6410 Rockledge Dr. #200 Bethesda, MD 20817

31. Date filed (Month, Day, Year) **JAN 20 2004** 32. Registrar's Signature *[Signature]*

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or Items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

**Physician
/Medical
Examiner**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Certification: To Be Completed by Physician/Medical Examiner

**State
Registrar**

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

1- For
State
Registrar

2004 03787

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at 905a.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) George Bess Sr.			2. Date of Death Month Day Year January 19, 2004		3. Time of Death 9:03 a M	
	4a. Facility Name (If not institution, give street and number) Holy Cross Hospital			4b. City, Town, or Location of Death Silver Spring		4c. County of Death Montgomery	
Funeral Director	5. Social Security Number 231-24-4165	6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F	7. Age (In yrs. last birthday) 76 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) Mar. 3, 1927	9. Birthplace (State or Foreign Country) Virginia
	Usual Residence of Decedent						
10a. State Maryland		10b. County Montgomery		10c. City, Town or Location Kensington		10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
10e. Street and Number 3207 Ferndale Street			10f. Zip Code 20895		10g. Citizen of What Country? USA		
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates: 1945-46		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+)			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Carpenter		16b. Kind of Business/Industry Construction		
17. Father's Name (First, Middle, Last) James R. Bess				18. Mother's Name (First, Middle, Maiden Surname) Minnie Pearl Chapman			
19a. Informant's Name/Relationship (Type, Print) Agnes Bess/ Wife				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3207 Ferndale Street, Kensington, MD 20895			
20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Metropolitan Crematory		Date January 21 2004		20c. Location - City or Town, State Alexandria, Virginia	
21. Signature of Funeral Service Licensee ► Brodley J. Amet		22. Name and Address of Facility Francis J. Collins Funeral Home Inc. 500 University Blvd. W., Silver Spring, MD 20901					
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
Immediate Cause (Final disease or condition resulting in death)		a. Coronary Artery Disease Due to (or as a consequence of):					Approximate Interval Between Onset and Death 15 years
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		b. Atherosclerotic Cardiovascular Disease Due to (or as a consequence of):					
		c. Hyperlipidemia Due to (or as a consequence of):					
		d.					
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 4 <input type="checkbox"/> Pregnant at time of death 9 <input type="checkbox"/> Unknown			3 <input type="checkbox"/> Ectopic pregnancy 5 <input type="checkbox"/> Other (Specify)		
					23d. Date of delivery Month Day Year		
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Carotid Artery Disease Left Bundle Branch Block Hypertension						23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown	
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No					
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
		28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			
		28f. Location (Street and Number or Rural Route Number, City or Town, State)					
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.							
29b. Signature and title of certifier ► [Signature]		29c. License number 16360		29d. Date signed (Month, Day, Year) 1/19/04			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Samuel D. Goldberg, MD 6410 Rockledge Dr Bethesda, MD 20817							
31. Date filed (Month, Day, Year) JAN 23 2004		32. Registrar's Signature ► [Signature]					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2004 03788

1- For
State
Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) LOUISE F. BIALEK				2. Date of Death Month Day Year JANUARY 15, 2004		3. Time of Death 10:30 A M						
	4a. Facility Name (If not institution, give street and number) CASEY HOUSE				4b. City, Town, or Location of Death ROCKVILLE		4c. County of Death MONTGOMERY						
Funeral Director	5. Social Security Number 579-36-9503	6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 73 Yrs.	8. Date of Birth (Month, Day, Year) DEC 9, 1930		9. Birthplace (State or Foreign Country) WASHINGTON, DC							
	Usual Residence of Decedent												
To Be Completed by Funeral Director	10a. State FLORIDA	10b. County PALM BEACH	10c. City, Town or Location HIGHLAND BEACH			10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No							
	10e. Street and Number 3912 S. OCEAN BLVD., #814			10f. Zip Code 33487		10g. Citizen of What Country? UNITED STATES							
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: WHITE						
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 1		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) HOMEMAKER		16b. Kind of Business/Industry OWN HOME								
	17. Father's Name (First, Middle, Last) ALEC OISBOID				18. Mother's Name (First, Middle, Maiden Surname) MINNIE BREGMAN								
	19a. Informant's Name/Relationship (Type, Print) BEN M. BIALEK, SON				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10913 GREAT OAK WAY, COLUMBIA, MD 21044								
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) KING DAVID MEM. GDN.		Date 1/18/2004		20c. Location - City or Town, State FALLS CHURCH, VA						
	21. Signature of Funeral Service Licensee 		22. Name and Address of Facility DANZANSKY-GOLDBERG MEMORIAL CHAPELS, INC. 1170 ROCKVILLE PIKE, ROCKVILLE, MD 20852										
	23a. Pertin. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.												
	<table border="1"> <tr> <td rowspan="4">Immediate Cause (Final disease or condition resulting in death)</td> <td>a. METASTATIC MALIGNANT MELANOMA</td> <td rowspan="4">Approximate Interval Between Onset and Death 6 MONTHS</td> </tr> <tr> <td>b. Due to (or as a consequence of):</td> </tr> <tr> <td>c. Due to (or as a consequence of):</td> </tr> <tr> <td>d. Due to (or as a consequence of):</td> </tr> </table>								Immediate Cause (Final disease or condition resulting in death)	a. METASTATIC MALIGNANT MELANOMA	Approximate Interval Between Onset and Death 6 MONTHS	b. Due to (or as a consequence of):	c. Due to (or as a consequence of):
Immediate Cause (Final disease or condition resulting in death)	a. METASTATIC MALIGNANT MELANOMA	Approximate Interval Between Onset and Death 6 MONTHS											
	b. Due to (or as a consequence of):												
	c. Due to (or as a consequence of):												
	d. Due to (or as a consequence of):												
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) 9 <input type="checkbox"/> Unknown		23d. Date of delivery Month Day Year									
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown							
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No						24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No							
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA		26. Place of Death Check on one Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other (Specify) HOSPICE									
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No							
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28d. Describe how injury occurred											
28f. Location (Street and Number or Rural Route Number, City or Town, State)													
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.													
29b. Signature and title of certifier 				29c. License number 00041218		29d. Date signed (Month, Day, Year) 1/15/04							
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CHARLES HARRISON, M.D., 6001 MUNCASTER MILL ROAD, ROCKVILLE, MD 20852													
31. Date filed (Month, Day, Year) JAN 20 2004		32. Registrar's Signature 											

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2004 03789

1- For
State
RegistrarPhysician
/Medical
Examiner1. Decedent's Name (First, Middle, Last)
Golam Kadir Bhuiyan2. Date of Death
Month Day Year
January 16, 20043. Time of Death
6:28A. MFuneral
Director4a. Facility Name (If not institution, give street and number)
Washington Adventist Hospital4b. City, Town, or Location of Death
Takoma Park4c. County of Death
Montgomery5. Social Security Number
215-49-65916. Sex
1 ☐ M 2 ☐ F
☒ M7. Age (In yrs. last birthday)
69 Yrs.If Under 1 Year
Months Days
If Under 24 Hrs.
Hours Min.8. Date of Birth
(Month, Day, Year)
Jan. 11, 19359. Birthplace (State or Foreign
Country)
Bangladesh

Usual Residence of Decedent

10a. State
Maryland10b. County
Montgomery10c. City, Town or Location
Silver Spring10d. Inside City Limits
1 ☐ Yes 2 ☒ No10e. Street and Number
1500 Jackson Road10f. Zip Code
2090410g. Citizen of What Country?
Bangladesh11. Marital Status
1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced12. Was Decedent Ever in U.S.
Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.
Specify: Asian15. Decedent's Education
(Specify only highest grade completed)
Elementary/Secondary (0-12) 12
College (1-4 or 5+)16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)
Farmer16b. Kind of Business/Industry
Agriculture17. Father's Name (First, Middle, Last)
Dud Mia Bhuiyan18. Mother's Name (First, Middle, Maiden Surname)
Hashmoter Nesa19a. Informant's Name/Relationship (Type, Print)
Jahanara Begum Bhuiyan -wife19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
1500 Jackson Road Silver Spring, Maryland 2090420a. Method of Disposition
1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)
George Washington Cem. 1/16/200420c. Location - City or Town, State
Adelphi, Maryland21. Signature of Funeral Service Licensee
Donald V. Borgwardt22. Name and Address of Facility
Donald V. Borgwardt Funeral Home, P.A.
4400 Powder Mill Rd. Beltsville, Maryland 2070523a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

a. Sepsis

Due to (or as a consequence of):

b. Clostridium difficile colitis

Due to (or as a consequence of):

c. End Stage Renal Disease

Due to (or as a consequence of):

d. Insulin dependent diabetes mellitus

Approximate
Interval Between
Onset and Death

1 day

1 month

6 mos

6 mos

IF FEMALE:

23b. Was decedent pregnant
in the past 12 months?
1 ☐ Yes 2 ☐ No
9 ☐ Unknown23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown3 ☐ Ectopic pregnancy
5 ☐ Other (specify)23d. Date of delivery
Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?
1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an
autopsy
performed?
1 ☐ Yes 2 ☒ No24b. Were autopsy findings available
prior to completion of cause of
death?
1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?
1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural
2 ☐ Accident
3 ☐ Suicide
4 ☐ Homicide5 ☐ Pending
investigation
6 ☐ Could not be
determined28a. Date of Injury
(Month, Day Year)28b. Time of
Injury28c. Injury at
Work?
1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.29b. Signature and title of certifier
Jacqueline Honig, M.D.29c. License number
D4822929d. Date signed (Month, Day, Year)
1/16/0430. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Jacquelin Honig, M.D. 7600 Carroll Avenue Takoma Park, Maryland 2091231. Date filed (Month, Day, Year)
JAN 21 200432. Registrar's Signature
[Signature]State
Registrar

Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28e-1 show any injury or other traumatic event, the Medical Examiner must be notified at 800.558.0058.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28e-1 show any injury or other traumatic event, the Medical Examiner must be notified at 800.558.0058.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2004 03790

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Donzel

E.

Betts

2. Date of Death

Month

Day

Year

January 14, 2004

3. Time of Death

9:10 PM

Funeral
Director

4a. Facility Name (If not institution, give street and number)

Manor Care-Chevy Chase

4b. City, Town, or Location of Death

Chevy Chase

4c. County of Death

Montgomery

5. Social Security Number

235-30-4609

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

80

Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

(Month, Day, Year)

March 20, 1923

9. Birthplace (State or Foreign Country)

West Virginia

Usual Residence of Decedent

10a. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Bethesda

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

5316 Yorktown Road

10f. Zip Code

20816

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☒ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☒ Yes 2 ☐ No

If Yes, Give Year or Dates: War II

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

5+

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Intelligence Analyst

16b. Kind of Business/Industry

National Security Agency

17. Father's Name (First, Middle, Last)

Fenton

W.

Betts

18. Mother's Name (First, Middle, Maiden Surname)

Ella

Connolly

19a. Informant's Name/Relationship (Type, Print)

Lillian Latimer Betts/Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

5316 Yorktown Road, Bethesda, Maryland 20816

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Westview Cemetery

Date

January

20c. Location - City or Town, State

Blacksburg, Virginia

21. Signature of Funeral Service Licensee

M01356

22. Name and Address of Facility

Robert A. Pumphrey Funeral Home/ Bethesda-Chevy Chase, Inc. 7557 Wisconsin Avenue Bethesda, Maryland 20814-3501

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Bilateral Aspiration Pneumonia

Due to (or as a consequence of):

b. Parkinson's Disease

Due to (or as a consequence of):

c. Hypothyroidism

Due to (or as a consequence of):

d. Dementia

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Kirti Vohra M.D.

29c. License number

D20274

29d. Date signed (Month, Day, Year)

January 16, 2004

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Kirti Vohra, M.D. 7710 Bradley Boulevard, Bethesda, Maryland 20817

31. Date filed (Month, Day, Year)

JAN 20 2004

32. Registrar's Signature

Benita B Sparks

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2004 03791

1- For
State
Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Basil Rudolph Barnett			2. Date of Death Month January Day 16 Year 2004		3. Time of Death 2135 M	
	4a. Facility Name (If not institution, give street and number) BROOK & GROVE REHABILITATION AND NURSING CENTER			4b. City, Town, or Location of Death Sandy Spring		4c. County of Death Montgomery	
Funeral Director	5. Social Security Number 487-12-0384		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 84 Yrs.		8. Date of Birth (Month, Day, Year) May 21, 1919
	9. Birthplace (State or Foreign Country) Kansas						
To Be Completed by Funeral Director	Usual Residence of Decedent						
	10a. State Maryland		10b. County Montgomery		10c. City, Town or Location Wheaton		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
	10e. Street and Number 12812 Atherton Drive			10f. Zip Code 20906		10g. Citizen of What Country? USA	
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: WWII		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 4 College (1-4 or 5+) 4		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Systems Budget Analyst		16b. Kind of Business/Industry Army Department		
	17. Father's Name (First, Middle, Last) Lee Barnett			18. Mother's Name (First, Middle, Maiden Surname) Maud Ethel Nicholas			
	19a. Informant's Name/Relationship (Type, Print) Katie K. Barnett Wife			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12812 Atherton Drive Wheaton, Maryland 20906			
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Gate of Heaven Cemetery		20c. Location - City or Town, State Jan. 20, 2004 Silver Spring, MD		
	21. Signature of Funeral Service Licensee Andrew J. Cole		22. Name and Address of Facility Francis J. Collins Funeral Home, Inc. 500 University Blvd., W., Silver Spring, MD 20901				
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Pneumonia Due to (or as a consequence of): b. Renal Failure Due to (or as a consequence of): c. Due to (or as a consequence of): d.						
Approximate Interval Between Onset and Death 4 days 4 days							
To Be Completed by Physician/Medical Examiner	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <input type="checkbox"/> Unknown		23d. Date of delivery Month Day Year		
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)				
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
	28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)		
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.						
	29b. Signature and title of certifier Christopher J. Mays, M.D.		29c. License number 539713		29d. Date signed (Month, Day, Year) January 17, 2004		
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Christopher J. Mays, MD 18111 Prince Philip Dr. #328 Olney, MD 20832						
	31. Date filed (Month, Day, Year) JAN 20 2004		32. Registrar's Signature Benjamin A. Sparks				

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23e or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2004 03792

1- For State Registrar

Physician /Medical Examiner

Funeral Director

1. Decedent's Name (First, Middle, Last) ELIZABETH M. BAKER		2. Date of Death Month Day Year JANUARY 16 2004		3. Time of Death 04:10 A M	
4a. Facility Name (If not institution, give street and number) MONTGOMERY GENERAL HOSPITAL		4b. City, Town, or Location of Death OLNEY		4c. County of Death MONTGOMERY	
5. Social Security Number 165 20 8655	6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 77 Yrs.	8. Date of Birth (Month, Day, Year) April 10 1926	9. Birthplace (State or Foreign Country) Pennsylvania	
Usual Residence of Decedent					
10a. State Md.	10b. County Montgomery	10c. City, Town or Location DAMASCUS		10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
10e. Street and Number 10109 Ridge Manor Terrace, Unit C		10f. Zip Code 20872		10g. Citizen of What Country? United States	
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:	
14. Race - American Indian, Black, White, etc. Specify: White		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 0		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Secretary	
16b. Kind of Business/Industry U. S. Government		17. Father's Name (First, Middle, Last) Thomas Conway		18. Mother's Name (First, Middle, Maiden Surname) Nora McNamara	
19a. Informant's Name/Relationship (Type, Print) Pamela M. Baker / Daughter		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 13406 Brandon Manor Court, Mt. Airy, Md. 21771			
20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Metropolitan Crem.		20c. Location - City or Town, State Alexandria, Virginia	
21. Signature of Funeral Service Licensee Muriel H. Barber		22. Name and Address of Facility Muriel H. Barber Funeral Home P. O. Box 5038, Laytonsville, Md. 20882			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. LUNG CANCER					
23b. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.					
23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (Specify)					
23d. Date of delivery Month Day Year					
23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input checked="" type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown					
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No					
24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No					
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No					
26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> OOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M	
28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	
28f. Location (Street and Number or Rural Route Number, City or Town, State)					
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.					
29b. Signature and title of certifier Joseph Kaplan, M.D.		29c. License number D35635		29d. Date signed (Month, Day, Year) January 16, 2004	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Joseph Kaplan, M.D. 18111 Prince Philip Drive, Olney, Md. 20832					
31. Date filed (Month, Day, Year) JAN 20 2004		32. Registrar's Signature B Sparks			

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0036
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2004 03793

1- For
State
RegistrarPhysician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

MIRIAM SHERMAN BACHRACH

2. Date of Death

Month Day Year
JANUARY 17, 2004

3. Time of Death

11:12 PM

4a. Facility Name (If not institution, give street and number)

SUBURBAN HOSPITAL

4b. City, Town, or Location of Death

BETHESDA

4c. County of Death

MONTGOMERY

Funeral
Director

5. Social Security Number

578-18-6181

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

81

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

APRIL 10, 1922 WASHINGTON, DC

9. Birthplace (State or Foreign Country)

Usual Residence of Decedent

10a. State

MARYLAND

10b. County

MONTGOMERY

10c. City, Town or Location

CHEVY CHASE

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

5607 WARWICK PLACE

10f. Zip Code

20815

10g. Citizen of What Country?

UNITED STATES

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: WHITE

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

1

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

HOMEMAKER

16b. Kind of Business/Industry

OWN HOME

17. Father's Name (First, Middle, Last)

LOUIS HARRISON SHERMAN

18. Mother's Name (First, Middle, Maiden Surname)

ANNIE FELD

19a. Informant's Name/Relationship (Type, Print)

JOAN-LEE SLATKIN, DAUGHTER

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

6109 COUNTRY CLUB DR., EASTON, MD 21601

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

ADAS ISRAEL CONG. CEM. 1/22/04

Date

20c. Location - City or Town, State

WASHINGTON, DC

21. Signature of Funeral Service Licensee

Donald C. Stottmeyer

22. Name and Address of Facility

DANZANSKY-GOLDBERG MEMORIAL CHAPELS, INC.
1170 ROCKVILLE PIKE, ROCKVILLE, MD 2085223a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

a. ISCHEMIC COLITIS

Due to (or as a consequence of):

b. ACUTE RENAL FAILURE

Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Sequentially list conditions,
if any, leading to immediate
cause. Enter underlying
Cause (Disease or injury
that initiated events
resulting in death) LastApproximate
Interval Between
Onset and Death

IF FEMALE:

23b. Was decedent pregnant
in the past 12 months?1 ☐ Yes 2 ☐ No
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy
4 ☐ Pregnant at time of death 5 ☐ Other (specify)
9 ☐ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an
autopsy
performed?1 ☒ Yes 2 ☐ No24b. Were autopsy findings available
prior to completion of cause of
death?1 ☐ Yes 2 ☒ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ NoHospital: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending
investigation
2 ☐ Accident 6 ☐ Could not be
determined
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury

(Month, Day Year)

28b. Time of
Injury

M

28c. Injury at
Work?1 ☐ Yes 2 ☐ No28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
and manner stated.

29b. Signature and title of certifier

Alpana Goswami M.D.

29c. License number

D27660

29d. Date signed (Month, Day, Year)

JANUARY 19, 2004

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ALPANA GOSWAMI, M.D., 10901 CONNECTICUT AVENUE, #100 KENSINGTON, MD 20895

State
Registrar

31. Date filed (Month, Day, Year)

JAN 22 2004

32. Registrar's Signature

Alpana Goswami

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or item 23a or 28a-f show
any injury or other traumatic event, the Medical Examiner must be notified at
once.Physician
/Medical
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial/transitBACHRACH, MIRIAM S 1/17/04
23:12 PM
Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2004 03794

1- For State Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Jermaine Belle				2. Date of Death Month Day Year JANUARY 15, 2004		3. Time of Death 9:40 P^M	
	4a. Facility Name (If not institution, give street and number) PRINCE GEORGES HOSPITAL CENTER				4b. City, Town, or Location of Death CHEVERLY		4c. County of Death PRINCE GEORGES CO	
Funeral Director	5. Social Security Number 579-13-3854		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 30 Yrs.		8. Date of Birth (Month, Day, Year) Sep. 3, 1973	
	9. Birthplace (State or Foreign Country) Wash., DC		10a. State District of Columbia		10b. County Washington		10c. City, Town or Location Washington	
10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		10e. Street and Number 441 - 15th St., N.E.		10f. Zip Code 20002		10g. Citizen of What Country? United States		
11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: Black		
15. Decedent's Education (Specify only highest grade completed) 12th		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Fire Fighter		16b. Kind of Business/Industry Government				
17. Father's Name (First, Middle, Last) Jerome B. Belle				18. Mother's Name (First, Middle, Maiden Surname) Ernestine Robinson				
19a. Informant's Name/Relationship (Type, Print) Ernestine T. Belle - Mother				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 441 - 15th St., N.E. Wash., DC 20002				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Harmony Memorial Park		20c. Date 1/22/04		20d. Location - City or Town, State Landover, MD		
21. Signature of Funeral Service Licensee <i>John T. Stewart III</i>		22. Name and Address of Facility Stewart Funeral Home		22. Address of Facility 4001 Benning Rd., N.E. Wash., DC 20019				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Contact gunshot wound to head								
23b. Enter the immediate cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter underlying cause (Disease or injury that initiated events resulting in death) Last								
23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify)								
23d. Date of delivery Month Day Year								
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								
23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown								
24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No								
24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No								
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year) 1/14/04		
28b. Time of Injury 1045 M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred Subject shot self		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) At home		
28f. Location (Street and Number or Rural Route Number, City or Town, State) 2701 Keating St. District Heights, MD		29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier <i>Zabill...</i>		29c. License number O C M E		
29d. Date signed (Month, Day, Year) JANUARY 18, 2004		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ZABILL ALI		31. Date filed (Month, Day, Year) JAN 22 2004		32. Registrar's Signature <i>[Signature]</i>		

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 23b-1 show any injury or other traumatic event, the Medical Examiner must be notified at 902-624.

Physician /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial/transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2004 03795

1- For State Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Iceline Ruby Burwell		2. Date of Death Month Day Year Jan. 13, 2004		3. Time of Death 20 35 p.m.
	4a. Facility Name (If not institution, give street and number) Southern Maryland Hospital		4b. City, Town, or Location of Death Clinton		4c. County of Death Prince George
Funeral Director	5. Social Security Number 577-54-8855	6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 62 Yrs.	8. Date of Birth (Month, Day, Year) Aug. 12, 1941	9. Birthplace (State or Foreign Country) N. Carolina
	Usual Residence of Decedent				
To Be Completed by Funeral Director	10a. State MD	10b. County Prince George	10c. City, Town or Location Upper Marlboro		10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No
	10e. Street and Number 12203 McCullagh		10f. Zip Code 20772		10g. Citizen of What Country? USA
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:
	14. Race - American Indian, Black, White, etc. Specify: Black		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4or 5+) 15		
	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Computer Programmer		16b. Kind of Business/Industry Dept. of Treasurer		
To Be Completed by Physician/Medical Examiner	17. Father's Name (First, Middle, Last) Rufus McNeal		18. Mother's Name (First, Middle, Maiden Surname) Lela Belle Rodgers		
	19a. Informant's Name/Relationship (Type, Print) William Burwell/Husband		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12203 McCullagh Ct. Upper Marlboro, MD 20772		
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Resurrection Cemetery		20c. Location - City or Town, State Clinton, MD
	21. Signature of Funeral Service Licensee 		22. Name and Address of Facility Strickland Funeral Services 6500 Allentown Rd, Camp Springs, MD 20748		
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Asystole minutes Due to (or as a consequence of): b. Hypoxia minutes Due to (or as a consequence of): c. Hypertension years Due to (or as a consequence of): d. Diabetes, hyperlipidemia years				
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 9 <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) 9 <input type="checkbox"/> Unknown		23d. Date of delivery Month Day Year	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.					
23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown					
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No					
24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No					
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No					
26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input checked="" type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined					
28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 28d. Describe how injury occurred 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)					
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.					
29b. Signature and title of certifier 29c. License number MD 1053276 29d. Date signed (Month, Day, Year) 11/21/04					
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Camp Springs Medical Center Temple Hills MD 20748					
31. Date filed (Month, Day, Year) JAN 21 2004 32. Registrar's Signature 					

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: Alter this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial/transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2004 03796

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

MARGARET BASS

2. Date of Death

Month 1 Day 15 Year 2004

3. Time of Death

11:00 AM

4a. Facility Name (If not institution, give street and number)

MANOR CARE NURSING

4b. City, Town, or Location of Death

LARGO

4c. County of Death

PRINCE GEORGE'S

Funeral
Director

5. Social Security Number

579-44-7947

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

95

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
2 29 1908

9. Birthplace (State or Foreign Country)

VIRGINIA

Usual Residence of Decedent

10a. State

MD

10b. County

PRINCE GEORGE'S

10c. City, Town or Location

UPPER MARLBORO

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

15255 CROOM AIR PORT ROAD

10f. Zip Code

20774

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: BLACK

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12th

College (1-4or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

MAID

16b. Kind of Business/Industry

PRIVATE

17. Father's Name (First, Middle, Last)

MERRINGTON THOMPSON

18. Mother's Name (First, Middle, Maiden Surname)

FANNIE RECTOR

19a. Informant's Name/Relationship (Type, Print)

JANICE MASON/NIECE

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

8618 SAPIENZA DRIVE FORT WASHINGTON, MARYLAND 20744

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

FT LINCOLN CEMETERY

Date

1-22-04

20c. Location - City or Town, State

BRENTWOOD, MARYLAND

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

J. B. JENKINS FUNERAL HOME

7474 LANDOVER ROAD LANDOVER, MARYLAND 20785

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

e. *CARDIO Pulmonary Failure*

Due to (or as a consequence of):

b. *Hypertension*

Due to (or as a consequence of):

c. *Diabetes mellitus*

Due to (or as a consequence of):

d. *Alzheimer's disease*

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Dementia

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☒ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number

51520

29d. Date signed (Month, Day, Year)

1-15-04

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

BAHRAM PISHDAD M.D. 1328 SOUTHERN AVENUE # 310 S.E. WASHINGTON, DC 20032

31. Date filed (Month, Day, Year)

JAN 21 2004

32. Registrar's Signature

*Heather K. Jones*State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2004 03797

1- For
State
RegistrarPhysician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Ida Mae Barbour

2. Date of Death

January 14, 2004

3. Time of Death

11 P. M

4a. Facility Name (If not institution, give street and number)

Suburban Hospital

4b. City, Town, or Location of Death

Bethesda

4c. County of Death

Montgomery

5. Social Security Number

579-60-5915

6. Sex

1 ☐ M ☒ F

7. Age (In yrs. last birthday)

79 Yrs.

If Under 1 Year

Months Days Hours Min.

If Under 24 Hrs.

8. Date of Birth (Month, Day, Year)

March 30, 1924

9. Birthplace (State or Foreign Country)

Washington, D.C.

Usual Residence of Decedent

10a. State

D.C.

10b. County

10c. City, Town or Location

Washington

10d. Inside City Limits

☒ Yes ☐ No

10e. Street and Number

2310 Skyland Place, S.E.

10f. Zip Code

20020

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

2

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Administrative Secretary

16b. Kind of Business/Industry

Elementary School

17. Father's Name (First, Middle, Last)

James H. Johnson

18. Mother's Name (First, Middle, Maiden Surname)

Ida Hillery

19a. Informant's Name/Relationship (Type, Print)

Mr. Lawrence Stafford Jones (Son)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2310 Skyland Place, S.E. Washington, D.C. 20020

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Lincoln Memorial Cemetery

Date

January 20, 2004

20c. Location - City or Town, State

Suitland, Maryland

21. Signature of Funeral Service Licensee

James C. Induser

22. Name and Address of Facility

ROLLINS FUNERAL HOME, INC.

4339 HUNT PL. N.E. WASHINGTON, D.C. 20019

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Pneumonia

a. Due to (or as a consequence of):

Ischemic Cardiomyopathy

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Approximate Interval Between Onset and Death

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☐ No
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy
4 ☐ Pregnant at time of death 5 ☐ Other (specify)
9 ☐ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23a. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy performed?
1 ☐ Yes 2 ☒ No24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Alpa Goswami M.D.

29c. License number

D27660

29d. Date signed (Month, Day, Year)

January 15, 2004

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Alpa Goswami, M.D. 11119 Rockville Pike Rockville, Md 20852

31. Date filed (Month, Day, Year)

JAN 21 2004

32. Registrar's Signature

John K. Smith

State
Registrar

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0036
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.Physician
/Medical
ExaminerTo the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial/transitBarbour, Ida Mae 4/14/04
Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2004 03798

1- For State Registrar

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial/transit permit.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

1. Decedent's Name (First, Middle, Last) JAMES ALTON BOWDEN				2. Date of Death Month Day Year January 15, 2004		3. Time of Death 6:00 P ^M	
4a. Facility Name (If not institution, give street and number) 105 Norair Avenue				4b. City, Town, or Location of Death Landover		4c. County of Death Prince George's	
5. Social Security Number 243-56-8120		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F XX		7. Age (In yrs. last birthday) 61 Yrs.		8. Date of Birth (Month, Day, Year) February 19, 42	
9. Birthplace (State or Foreign Country) N. Carolina		10a. State MD		10b. County Prince George's		10c. City, Town or Location Landover	
10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		10e. Street and Number 7216 Flagstaff Street		10f. Zip Code 20785		10g. Citizen of What Country? U.S.A.	
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: Black	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12th		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Bus Driver		16b. Kind of Business/Industry Metro			
17. Father's Name (First, Middle, Last) John Rowley				18. Mother's Name (First, Middle, Maiden Surname) Beulah Bowden			
19a. Informant's Name/Relationship (Type, Print) Dorothy Bowden - Wife				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7216 Flagstaff Street; Landover, MD 20785			
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Harmony Mem. Park		20c. Location - City or Town, State Landover, Maryland		20d. Date 01/22/2004	
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility Robert O. Freeman Funeral Services, Inc. 1353 H Street, N.E. Washington, D.C. 20002			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. <u>ERSD</u> Due to (or as a consequence of): b. <u>Multiple Myeloma</u> Due to (or as a consequence of): c. <u>Anemia</u> Due to (or as a consequence of): d. <u>HTN</u> Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last							
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No 9 Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Unknown		3 Ectopic pregnancy 5 Other (specify)		23d. Date of delivery Month Day Year	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>Bronchitis</u>						23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown	
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) <u>2nd Home</u>		24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. Signature and title of certifier 				29c. License number D57770		29d. Date signed (Month, Day, Year) 01/20/2004	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Vijaya Ganta 1221 Mercantile Lane; Upper Marlboro, MD 20774							
31. Date filed (Month, Day, Year) JAN 20 2004				32. Registrar's Signature 			

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2004 03799

1- For
State
RegistrarPhysician
/Medical
ExaminerFuneral
Director

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

1. Decedent's Name (First, Middle, Last) Julius G. Brooks III		2. Date of Death Month January Day 15 Year 2004		3. Time of Death 1800 M	
4a. Facility Name (If not institution, give street and number) 1001 Jansen Avenue		4b. City, Town, or Location of Death Capitol Heights		4c. County of Death Prince Georges	
5. Social Security Number 578-70-2139	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 50 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) June 07 1953
9. Birthplace (State or Foreign Country) DC					
10a. State Md		10b. County Prince George		10c. City, Town or Location Capitol Heights	
10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No					
10e. Street and Number 1001 Jansen Street		10f. Zip Code		10g. Citizen of What Country? USA	
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:	
14. Race - American Indian, Black, White, etc. Specify: Black		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 8th College (1-4or 5+)			
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Contractor Laborer		16b. Kind of Business/Industry Smith Home Improvement			
17. Father's Name (First, Middle, Last) Julius G. Brooks Jr.		18. Mother's Name (First, Middle, Maiden Surname) Mae Alice Johnson			
19a. Informant's Name/Relationship (Type, Print) Darlene Smith (Sister)		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1908 Palmer Park Road Landover Md. 20785			
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Riverdale Pk Crem		20c. Location - City or Town, State Jan 22 04 Riverdale Maryland	
21. Signature of Funeral Service Licensee 		22. Name and Address of Facility Tyrone J. Young 719 Kennedy St. NW			
23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Atherosclerotic Cardiovascular Heart Disease Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last					
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <input type="checkbox"/> Unknown		23d. Date of delivery Month Day Year	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown	
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M	
28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred			
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.					
29b. Signature and title of certifier 		29c. License number 140055927		29d. Date signed (Month, Day, Year) January 17, 2004	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Salvador S. Rivera 300 Hospital Drive, Chevy Chase, Maryland					
31. Date filed (Month, Day, Year) JAN 22 2004		32. Registrar's Signature 			

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

1- For
State
Registrar

2004 03800

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Edna D. Carlson				2. Date of Death Month Jan. Day 16 Year 2004		3. Time of Death 0020 M	
	4a. Facility Name (If not institution, give street and number) Shady Grove Advt. Hospital				4b. City, Town, or Location of Death Rockville		4c. County of Death Montgomery	
Funeral Director	5. Social Security Number 061-10-9457		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 86 Yrs.		8. Date of Birth (Month, Day, Year) Feb. 16, 1917	
	9. Birthplace (State or Foreign Country) New York		10a. State Md.		10b. County Montgomery		10c. City, Town or Location Rockville	
To Be Completed by Funeral Director	10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No				10e. Street and Number 9701- Veirs Drive		10f. Zip Code 20850	
	10g. Citizen of What Country? USA				11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:	
To Be Completed by Physician/Medical Examiner	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: White		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4or 5+)	
	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker				16b. Kind of Business/Industry At Home			
To Be Completed by Physician/Medical Examiner	17. Father's Name (First, Middle, Last) Edwin E. Engborg				18. Mother's Name (First, Middle, Maiden Surname) Ida Nilsson			
	19a. Informant's Name/Relationship (Type, Print) Rev. Dr. Reichard-Executor				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9701- Veirs Dr., Rockville, Md. 20850			
To Be Completed by Physician/Medical Examiner	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Glenwood Cemetery- Jan. 20/04			
	20c. Location - City or Town, State Washington, DC				21. Signature of Funeral Service Licensee W. W. Hysong			
To Be Completed by Physician/Medical Examiner	22. Name and Address of Facility Hysong Co., Inc. 6510-16th St., NW, Wash., DC				23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Myocardial Infarction Due to (or as a consequence of): GI bleed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last 3 days 3 days			
	23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 9 <input type="checkbox"/> Unknown				23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) 9 <input type="checkbox"/> Unknown			
To Be Completed by Physician/Medical Examiner	23d. Date of delivery Month Day Year				23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown			
	24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No			
To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined				28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 28d. Describe how injury occurred 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)			
To Be Completed by Physician/Medical Examiner	29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				29b. Signature and title of certifier Robert Gold MD			
	29c. License number 29300				29d. Date signed (Month, Day, Year) January 18, 2004			
To Be Completed by Physician/Medical Examiner	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Robert Gold 15225 Shady Grove Road Rockville, Md				31. Date filed (Month, Day, Year) JAN 20 2004			
	32. Registrar's Signature John K. Smith				33. Registrar's Title Registrar			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2004 03801

1- For
State
RegistrarPhysician
/Medical
ExaminerFuneral
Director

1. Decedent's Name (First, Middle, Last)

Linda Cheryl Coombs-Miller

2. Date of Death

Month Day Year
January 14, 2004

3. Time of Death

6:18 A. M.

4a. Facility Name (If not institution, give street and number)

Holy Cross Hospital

4b. City, Town, or Location of Death

Silver Spring

4c. County of Death

Montgomery

5. Social Security Number

578-70-5409

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

52 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year) 1951

9. Birthplace (State or Foreign Country)

Washington, D.C.

Usual Residence of Decedent

10a. State

District of Columbia

10b. County

10c. City, Town or Location

Washington

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

1216 Longfellow Street, N. W.

10f. Zip Code

20011

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: Black

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

2 years

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Administrative Assistant

16b. Kind of Business/Industry
U.S. Dept. of Health
& Human Services

17. Father's Name (First, Middle, Last)

Leonard Augustine Coombs

18. Mother's Name (First, Middle, Maiden Surname)

Dorothy Lucille Brice

19a. Informant's Name/Relationship (Type, Print)

Leonard A. Coombs (Father)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1216 Longfellow Street, N.W.; Washington, D.C. 20011

20a. Method of Disposition

1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Chesapeake Crematory, Inc.

Date
Jan. 21, 2004

20c. Location - City or Town, State

Beltsville, Maryland

21. Signature of Funeral Service Licensee

Karnamah Cham

22. Name and Address of Facility

R. N. Horton Company Morticians, Inc.
600 Kennedy Street, N.W.; Washington, D.C. 2001123a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Approximate
Interval Between
Onset and DeathImmediate Cause (Final
disease or condition
resulting in death)

a. Massive Stroke

Due to (or as a consequence of):

b. Hypertension

Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

IF FEMALE:

23b. Was decedent pregnant
in the past 12 months?1 ☐ Yes 2 ☒ No
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 5 ☐ Other (Specify)
9 ☐ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Human Immunodeficiency Virus

Drug Addiction

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an
autopsy
performed?
1 ☐ Yes 2 ☒ No24b. Were autopsy findings available
prior to completion of cause of
death?
1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation
6 ☐ Could not be determined28a. Date of Injury
(Month, Day Year)28b. Time of
Injury28c. Injury at
Work?M 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Catherine Godfrey

29c. License number

D0059151

29d. Date signed (Month, Day, Year)

1/14/04

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Catherine Godfrey, M.D.; 1500 Forest Glen Road, Silver Spring, Maryland 20910

31. Date filed (Month, Day, Year)

JAN 20 2004

32. Registrar's Signature

Karnamah Cham

State
Registrar

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or item 23a or 28e-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2004 03802

1- For State Registrar

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

WILLIAM ERNEST CARTER

2. Date of Death

January 15, 2004

3. Time of Death

1:05PM

Funeral
Director

4a. Facility Name (If not institution, give street and number)

Holy Cross Hospital

4b. City, Town, or Location of Death

Silver Spring

4c. County of Death

Montgomery

5. Social Security Number

578-54 2540

6. Sex

1X M 2□ F

7. Age (In yrs. last birthday)

63

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
01-09-1941

9. Birthplace (State or Foreign Country)

Washington, DC

Usual Residence of Decedent

10a. State

MD

10b. County

Montgomery

10c. City, Town or Location

Silver Spring

10d. Inside City Limits

XX Yes 2□ No

10e. Street and Number

700 Horton Drive

10f. Zip Code

20902

10g. Citizen of What Country?

USA

11. Marital Status

1□ Never Married 2□ Married

3□ Widowed 4X Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1X Yes 2□ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1□ Yes 2X No Specify:

14. Race - American Indian, Black, White, etc.

Black

Specify:

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4or 5+)

3+

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Project Manager

16b. Kind of Business/Industry

DC Gov't

17. Father's Name (First, Middle, Last)

Francis Carter

18. Mother's Name (First, Middle, Maiden Sumame)

Helen Tolson

19a. Informant's Name/Relationship (Type, Print)

Dennis Hawkins Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

12642 Grey Eagle Ct., #43, Germantown, MD 29874

20a. Method of Disposition

1X Burial 2□ Cremation 3□ Removal from State

4□ Donation 5□ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Lincoln Memorial

Date

01/21/04

20c. Location - City or Town, State

Suitland, MD

21. Signature of Funeral Service Licensee

H01257

22. Name and Address of Facility

Bianchi 814 Upshur Street NW Wash, DC 20011

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Congestive Heart Failure

Due to (or as a consequence of):

Hyperlipidemia

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1□ Yes 2□ No

9□ Unknown

23c. If yes, outcome of pregnancy

1□ Live birth 2□ Fetal death

4□ Pregnant at time of death

9□ Unknown

3□ Ectopic pregnancy

5□ Other (specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Hypertension

23e. Did tobacco use contribute to the cause of death?

1X Yes 2□ No 3□ Probably 4□ Unknown

24a. Was an autopsy performed?

1□ Yes 2X No

24b. Were autopsy findings available prior to completion of cause of death?

1□ Yes 2□ No

25. Was case referred to medical examiner?

1□ Yes 2X No

Hospital:

1□ Inpatient 2□ ER/Outpatient

3X DOA

26. Place of Death (Check only one)

Other: 4□ Nursing Home 5□ Residence 6□ Other (Specify)

27. Manner of Death

1X Natural 5□ Pending investigation

2□ Accident

3□ Suicide

4□ Homicide

6□ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1□ Yes 2□ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2□ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Khanh Q. Nsuten

29c. License number

H0059837

29d. Date signed (Month, Day, Year)

01/17/2004

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Khanh Q. Nsuten 1500 Forest Glen Road, Silver Spring, MD 20910

31. Date filed (Month, Day, Year)

JAN 20 2004

32. Registrar's Signature

Khanh Q. Nsuten

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2004 03803

1- For
State
RegistrarPhysician
/Medical
ExaminerFuneral
Director

1. Decedent's Name (First, Middle, Last)

Margie Edith Davis

2. Date of Death
Month Day Year
January 19, 20043. Time of Death
8:40 P M

4a. Facility Name (If not institution, give street and number)

Rockville Nursing Home

4b. City, Town, or Location of Death

Rockville

4c. County of Death

Montgomery

5. Social Security Number

384-16-2387

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

86

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth (Month, Day, Year)

March 9, 1917

9. Birthplace (State or Foreign Country)

Michigan

Usual Residence of Decedent

10a. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Rockville

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

303 Adclare Road

10f. Zip Code

20850

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: White

15. Decedent's Education
(Specify only highest grade completed)Elementary/Secondary (0-12)
12

College (1-4or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Office Worker

16b. Kind of Business/Industry

Manufacturing

17. Father's Name (First, Middle, Last)

Ervin Groner

18. Mother's Name (First, Middle, Maiden Surname)

Bertha Potter

19a. Informant's Name/Relationship (Type, Print)

Judith Hubbard/Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

204 Massbury Street, Gaithersburg, MD 20878

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Lakeview Cemetery

Date

January
26, 2004

20c. Location - City or Town, State

Ludington, Michigan

21. Signature of Funeral Service Licensee

William A. Pumphrey

M01173

22. Name and Address of Facility
Robert A. Pumphrey Funeral Home,
Bethesda-Chevy Chase, Inc., 7557 Wisconsin Ave.,
Bethesda, Maryland 2081423a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

a. Hypertensive Heart Disease

Due to (or as a consequence of):

b. Respiratory Failure

Due to (or as a consequence of):

c. Pneumonia

Due to (or as a consequence of):

d. Dementia

Approximate
Interval Between
Onset and Death

IF FEMALE:

23b. Was decedent pregnant
in the past 12 months?
1 ☐ Yes 2 ☒ No
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy
4 ☐ Pregnant at time of death 5 ☐ Other (specify)23d. Date of delivery
Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an
autopsy
performed?
1 ☐ Yes 2 ☒ No24b. Were autopsy findings available
prior to completion of cause of
death?
1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?
1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation
6 ☐ Could not be determined28a. Date of Injury
(Month, Day Year)28b. Time of
Injury28c. Injury at
Work?
1 ☐ Yes 2 ☐ No28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Thomas V. Joseph, M.D.

29c. License number

D47330

29d. Date signed (Month, Day, Year)

January 20, 2004

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Thomas V. Joseph, M.D. 50 West Edmonston Drive #207, Rockville, MD 20852

31. Date filed (Month, Day, Year)

JAN 22 2004

32. Registrar's Signature

B Sparks

Baltimore, Maryland 21215-0036

permi. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or item 23a or 28a-f show
any injury or other traumatic event, the Medical Examiner must be notified at
once.Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

10

State
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2004 03804

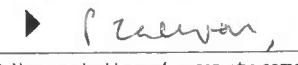

Certificate of Death

Reg. No.

1- For State Registrar

Physician /Medical Examiner

Funeral Director

1. Decedent's Name (First, Middle, Last) Robert Dean Dikkers		2. Date of Death Month January Day 17 , Year 2004		3. Time of Death 4:20 AM	
4a. Facility Name (If not institution, give street and number) Suburban Hospital		4b. City, Town, or Location of Death Bethesda		4c. County of Death Montgomery	
5. Social Security Number 319-24-9113		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 73 Yrs.	
8. Date of Birth (Month, Day, Year) Jan. 19, 1930		9. Birthplace (State or Foreign Country) Illinois			
Usual Residence of Decedent					
10a. State Maryland		10b. County Montgomery		10c. City, Town or Location Bethesda	
10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
10e. Street and Number 9309 Singleton Drive		10f. Zip Code 20817		10g. Citizen of What Country? United States	
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: 1954-1956		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:	
14. Race - American Indian, Black, White, etc. Specify: White					
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <input type="checkbox"/> College (1-4or 5+) <input checked="" type="checkbox"/> 5+		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Civil Engineer		16b. Kind of Business/Industry Federal Government	
17. Father's Name (First, Middle, Last) John Dikkers		18. Mother's Name (First, Middle, Maiden Surname) Margaret Piltz			
19a. Informant's Name/Relationship (Type, Print) Caryl M. Dikkers/Wife		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9309 Singleton Drive, Bethesda, Maryland 20817			
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Montgomery Crematorium		20c. Location - City or Town, State Bethesda, Maryland	
21. Signature of Funeral Service Licensee  M00198		22. Name and Address of Facility Robert A. Pumphrey Funeral Home/ Bethesda-Chevy Chase, Inc. 7557 Wisconsin Ave., Bethesda, MD 20814-3501			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) ASPIRATION PNEUMONIA Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last CEREBRO VASCULAR ACCIDENT Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):					
Approximate Interval Between Onset and Death 1 DAY MONTHS					
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input checked="" type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <input type="checkbox"/> Unknown		23d. Date of delivery Month January Day 19 Year 2004	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.					
23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown					
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year) January 17, 2004		28b. Time of Injury M	
28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred			
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.					
29b. Signature and title of certifier  P. Talwar, MD		29c. License number D36552		29d. Date signed (Month, Day, Year) JANUARY 19, 2004	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) P. Talwar, 50 W. Edmonston Drive #401, Rockville MD 20852					
31. Date filed (Month, Day, Year) JAN 22 2004		32. Registrar's Signature 			

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

State Registrar

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2004 03805

1- For
State
RegistrarPhysician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

MARGARET GEIB

2. Date of Death

Month

Day

Year

January 15

2004

12:05A M

3. Time of Death

4a. Facility Name (If not institution, give street and number)

The Johns Hopkins Hospital

4b. City, Town, or Location of Death

Baltimore City

4c. County of Death

5. Social Security Number

214-36-4985

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

62 Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

Month

Day

Year

Feb. 14, 1941

9. Birthplace (State or Foreign Country)

Washington, D.C.

Usual Residence of Decedent

10a. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Burtonsville

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

14621 Old Columbia Pike

10f. Zip Code

20866-0028

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☒ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

School Teacher

16b. Kind of Business/Industry

Montgomery County

Public Schools

17. Father's Name (First, Middle, Last)

F. Ellsworth Geib

18. Mother's Name (First, Middle, Maiden Surname)

Margaret Marie Bock

19a. Informant's Name/Relationship (Type, Print)

James G. Dodson, Sr. -Husband

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

Post Office Box 28

Burtonsville, Maryland 20866

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Union Cemetery

Date

1/20/2004

20c. Location - City or Town, State

Burtonsville, Maryland

21. Signature of Funeral Service Licensee

Donald V. Borgwardt

22. Name and Address of Facility

Donald V. Borgwardt Funeral Home, P.A.

4400 Powder Mill Rd. Beltsville, Maryland 20705

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. SEPSIS

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death
19 days

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☒ No9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death4 ☐ Pregnant at time of death9 ☐ Unknown3 ☐ Ectopic pregnancy5 ☐ Other (specify)

23d. Date of delivery

Month

Day

Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☒ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

David Lim M.D.

29c. License number

RES-000

29d. Date signed (Month, Day, Year)

JANUARY 15, 2004

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DAVID LIM 600 NORTH WOLFE STREET, BALTIMORE, MARYLAND 21287

31. Date filed (Month, Day, Year)

JAN 21 2004

32. Registrar's Signature

Jennifer G. Sparks

State
Registrar

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23e or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.


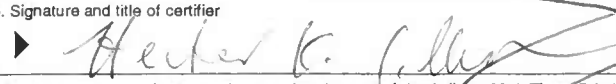
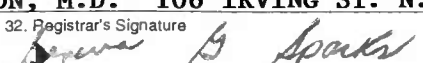
State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2004 03806

1- For
State
Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) MYRA C. DONAWA				2. Date of Death Month Day Year JAN. 19, 2004		3. Time of Death 9:30 A^M				
	4a. Facility Name (If not institution, give street and number) 409 CARONA PL.				4b. City, Town, or Location of Death SILVER SPRING		4c. County of Death MONTGOMERY				
Funeral Director	5. Social Security Number 218-64-7264		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 82 Yrs.		8. Date of Birth (Month, Day, Year) SEPT. 28, 1921				
	9. Birthplace (State or Foreign Country) TRINIDAD		10a. State MD.		10b. County MONTGOMERY		10c. City, Town or Location SILVER SPRING				
Usual Residence of Decedent		10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		10e. Street and Number 409 CARONA PL.		10f. Zip Code 20905		10g. Citizen of What Country? TRINIDAD			
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: BLACK					
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 8 College (1-4or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) CLERK		16b. Kind of Business/Industry COCA COLA CO.							
17. Father's Name (First, Middle, Last) EVAN MCGREGOR				18. Mother's Name (First, Middle, Maiden Surname) MAY CUMBERBATCH							
19a. Informant's Name/Relationship (Type, Print) ULRIC T. DONAWA/SON				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11405 SEQUOIA LA., BELTSVILLE, MD. 20705							
20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) CHAMBERS CREMATORY		Date 1-22-2004		20c. Location - City or Town, State RIVERDALE, MD.					
21. Signature of Funeral Service Licensee 		M00091		22. Name and Address of Facility CHAMBERS FUNERAL HOME & CREMATORIUM, P.A. 5801 CLEVELAND AVE., RIVERDALE, MD. 20737							
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. CEREBRO VASCULAR ACCIDENT Due to (or as a consequence of): b. ARTERIOSCLEROSIS Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last								Approximate Interval Between Onset and Death			
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 9 <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 4 <input type="checkbox"/> Pregnant at time of death 9 <input type="checkbox"/> Unknown 3 <input type="checkbox"/> Ectopic pregnancy 5 <input type="checkbox"/> Other (specify)				23d. Date of delivery Month Day Year					
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown					
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)						24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred			
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)					
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier 		29c. License number 0111190		29d. Date signed (Month, Day, Year) January 21, 2004					
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) HECTOR COLLISON, M.D. 106 IRVING ST. N.W., WASHINGTON, D.C. 20010											
31. Date filed (Month, Day, Year) JAN 22 2004		32. Registrar's Signature 									

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2004 03807

1- For
State
RegistrarPhysician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Eleanor H. Dixon

2. Date of Death

January 15, 2004

3. Time of Death

3:20 A. M

4a. Facility Name (If not institution, give street and number)

Prince George's Hospital Center

4b. City, Town, or Location of Death

Cheverly

4c. County of Death

Prince George's

Funeral
Director

5. Social Security Number

578-24-0268

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

89 Yrs.

If Under 1 Year

Months

If Under 24 Hrs.

Days

Hours

Min.

8. Date of Birth

February 21, 1914

9. Birthplace (State or Foreign Country)

North Carolina

Usual Residence of Decedent

10a. State

Maryland

10b. County

Prince George's

10c. City, Town or Location

Glenarden

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

7903 Dellwood Avenue

10f. Zip Code

20706

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)
12th grade

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Direct Care Aide

16b. Kind of Business/Industry

Home On Aging (Retired)

17. Father's Name (First, Middle, Last)

Luther Hairston

18. Mother's Name (First, Middle, Maiden Surname)

Earline Oakes

19a. Informant's Name/Relationship (Type, Print)

Mrs. Eleanor J. Johnson (Daughter)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

7903 Dellwood Avenue Glenarden, Maryland 20706

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Harmony Memorial Cemetery

Date

January 22, 2004 Landover, Maryland

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

Janet C. Anderson

22. Name and Address of Facility

ROLLINS FUNERAL HOME, INC.

4339 HUNT PL. N.E. WASHINGTON, D.C. 20019

23a. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Pulmonary Embolism

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Respiratory Insufficiency

c. Congestive Heart Failure

d. Arrhythmia

Approximate Interval Between Onset and Death

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☐ No
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 5 ☐ Other (specify)
9 ☐ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Sepsis
Pneumonia
Multi-organ failure

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

D. Berger

29c. License number

D0054794

29d. Date signed (Month, Day, Year)

01/16/2004

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Derege Z. Haile, MD 6005 Landover Rd, Suite #3, Cheverly, MD, 20785

31. Date filed (Month, Day, Year)

JAN 21 2004

32. Registrar's Signature

John A. Smith

State
Registrar

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

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To Be Completed by Funeral Director

Medical Certification; To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2004 03808

1- For State Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Lawrence A. DiBari, Jr.				2. Date of Death Month Day Year January 15, 2004		3. Time of Death 12:30PM ^M	
	4a. Facility Name (If not institution, give street and number) 11905 Piscataway Road				4b. City, Town, or Location of Death Clinton		4c. County of Death Prince Georges	
Funeral Director	5. Social Security Number 579-52-4203		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 65 Yrs.		8. Date of Birth (Month, Day, Year) Oct. 17, 1938	
	9. Birthplace (State or Foreign Country) Washington, D.C.		10a. State Maryland		10b. County Prince Georges		10c. City, Town or Location Clinton	
To Be Completed by Funeral Director	10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		10e. Street and Number 11905 Piscataway Road		10f. Zip Code 20735		10g. Citizen of What Country? USA	
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: 1951-72		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <input type="checkbox"/> College (1-4 or 5+) <input checked="" type="checkbox"/> 1		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Military		16b. Kind of Business/Industry U.S. Navy			
	17. Father's Name (First, Middle, Last) Lawrence Aloysius DiBari				18. Mother's Name (First, Middle, Maiden Surname) Cecelia Deaver			
	19a. Informant's Name/Relationship (Type, Print) Christopher DiBari / Son				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11905 Piscataway Rd., Clinton, MD 20735			
	20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Kalas Crematory		Date 1/16/2004		20c. Location - City or Town, State Edgewater, MD	
	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility George P. Kalas Funeral Home, P.A. 6160 Oxon Hill Rd., Oxon Hill, MD 20745			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Head and Neck Cancer Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last							
	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Other (specify) <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Unknown				23d. Date of delivery Month Day Year	
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23e. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown	
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No						
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
28d. Describe how injury occurred				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				
28f. Location (Street and Number or Rural Route Number, City or Town, State)								
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier 		29c. License number LA 023686		29d. Date signed (Month, Day, Year) January 16, 2004		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Brian Heller, M.D. 1050 W. Perimeter Rd., #BB-50, Andrews A.F.B., MD 20762								
31. Date filed (Month, Day, Year) JAN 20 2004		32. Registrar's Signature 						

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2004 03809

1- For
State
RegistrarPhysician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Zepha

Irene

Dwyer

2. Date of Death

January

Day

Year

17, 2004

3. Time of Death

12:28

Funeral
Director

4a. Facility Name (If not institution, give street and number)

Casey House

4b. City, Town, or Location of Death

Rockville

4c. County of Death

Montgomery

5. Social Security Number

577-20-6800

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

83

Yrs.

If Under 1 Year

Months

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

(Month, Day, Year)

Dec. 12, 1920

9. Birthplace (State or Foreign Country)

Washington; DC

Usual Residence of Decedent

10a. State

Maryland

10b. County

Prince Georges

10c. City, Town or Location

Hyattsville

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

5805 42nd Avenue

10f. Zip Code

20781

10g. Citizen of What Country?

United States America

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: White

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

12

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Clerical

16b. Kind of Business/Industry

National Geographic

17. Father's Name (First, Middle, Last)

Thomas Edward Crane

18. Mother's Name (First, Middle, Maiden Surname)

Zepha Roles

19a. Informant's Name/Relationship (Type, Print)

Irene J. Purdy/Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

6528 Quiet Hours Columbia, MD 21045

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Fort Lincoln Cemetery

Date

1/20/2004

20c. Location - City or Town, State

Brentwood, Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Fort Lincoln Funeral Home

3401 Bladensburg Road Brentwood, Maryland 20722

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Approximate
Interval Between
Onset and DeathImmediate Cause (Final
disease or condition
resulting in death)

a. Cardiopulmonary Disease

Due to (or as a consequence of):

b. Leukemia

Due to (or as a consequence of):

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

IF FEMALE:

23b. Was decedent pregnant
in the past 12 months?
1 ☐ Yes 2 ☒ No
9 ☐ Unknown23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown3 ☐ Ectopic pregnancy
5 ☐ Other (Specify)23d. Date of delivery
Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23a. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown24a. Was an
autopsy
performed?
1 ☐ Yes 2 ☒ No24b. Were autopsy findings available
prior to completion of cause of
death?
1 ☐ Yes 2 ☒ No25. Was case referred to medical
examiner?
1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☒ Other (Specify) Hospice

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation
6 ☐ Could not be determined28a. Date of Injury
(Month, Day Year)28b. Time of
Injury

M

28c. Injury at
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
and manner stated.

29b. Signature and title of certifier

29c. License number

D60582

29d. Date signed (Month, Day, Year)

1/17/2004

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Joyson Karakunnel - 6001 Muncaster Hill Rd Rockville, Md 20850

31. Date filed (Month, Day, Year)

JAN 20 2004

32. Registrar's Signature

State
Registrar

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show
any injury or other traumatic event, the Medical Examiner must be notified at
once.Physician
/Medical
ExaminerTo the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification; To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2004 03810

1- For
State
RegistrarPhysician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Ruth Michael Dodson

2. Date of Death

Month Day Year
January 21, 2004

3. Time of Death

1:45 a M

Funeral
Director

4a. Facility Name (If not institution, give street and number)

Anne Arundel Medical Center

4b. City, Town, or Location of Death

Annapolis

4c. County of Death

Anne Arundel

5. Social Security Number

578-26-0943

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

79 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
Feb. 24, 1924

9. Birthplace (State or Foreign Country)

Washington, DC

Usual Residence of Decedent

10a. State

Maryland

10b. County

Prince George's

10c. City, Town or Location

West Hyattsville

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

3105 Kimberly Road

10f. Zip Code

20782

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give

Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify:

White

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

Banquet Waitress

16b. Kind of Business/Industry

Sheraton

17. Father's Name (First, Middle, Last)

Henry Raymond Carll

18. Mother's Name (First, Middle, Maiden Surname)

Thelma Pyles

19a. Informant's Name/Relationship (Type, Print)

Robert Ray Dodson - Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1905 Harcourt Avenue, Crofton, MD 21114

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Fort Lincoln Cemetery

Date

01/26/2004

20c. Location - City or Town, State

Brentwood, Maryland

21. Signature of Funeral Service Licensee

Chaudette Dorch Lanning

22. Name and Address of Facility

Gasch's Funeral Home, P.A.
4739 Baltimore Avenue, Hyattsville, MD 20781

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate
Interval Between
Onset and DeathImmediate Cause (Final
disease or condition
resulting in death)

a. End Stage Chronic Obstructive Pulmonary Disease

Due to (or as a consequence of):

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

IF FEMALE:

23b. Was decedent pregnant

in the past 12 months?

1 ☐ Yes 2 ☐ No3 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death4 ☐ Pregnant at time of death5 ☐ Other (specify)9 ☐ Unknown3 ☐ Ectopic pregnancy5 ☐ Other (specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an

autopsy

performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available

prior to completion of cause of

death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical

examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☒ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending2 ☐ Accident 6 ☐ investigation3 ☐ Suicide 6 ☐ Could not be4 ☐ Homicide 6 ☐ determined

28a. Date of Injury

(Month, Day Year)

28b. Time of

Injury

28c. Injury at

Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office

building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number,

City or Town, State)

29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Gabby Fossett M.D.

29c. License number

D0052555

29d. Date signed (Month, Day, Year)

January 22, 2004

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Gabby Fossett, M.D., 6525 Belcrest Road, Ste. 150, Hyattsville, MD 20782

31. Date filed (Month, Day, Year)

JAN 23 2004

32. Registrar's Signature

Heidi K. Smith

State
Registrar

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification; To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

2004 03811

1- For State Registrar

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Catherine C. Deane				2. Date of Death Month: 01 Day: 16 Year: 04		3. Time of Death 8:14 A^M	
	4a. Facility Name (If not institution, give street and number) Washington Adventist Hospital				4b. City, Town, or Location of Death Takoma Park		4c. County of Death Montgomery	
Funeral Director	5. Social Security Number 229-03-6845		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 85 Yrs.		8. Date of Birth (Month, Day, Year) 02 21 18	
	9. Birthplace (State or Foreign Country) Richmond, VA.		10a. State D.C.		10b. County Washington		10c. City, Town or Location Washington	
10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		10e. Street and Number 654 Girard Street N.W. #103		10f. Zip Code 20001		10g. Citizen of What Country? USA		
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: Black		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 3 yrs.		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Supervisor of Bacteriology		16b. Kind of Business/Industry Howard University Hosp.				
17. Father's Name (First, Middle, Last) Charlie Crawley				18. Mother's Name (First, Middle, Maiden Surname) Sarah Winfrey				
19a. Informant's Name/Relationship (Type, Print) Karen W. Atkins Niece				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5409 Arnold Drive, Lanham, MD. 20706				
20a. Method of Disposition <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input checked="" type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Harmony Memorial Park		20c. Date 1-24-04		20d. Location - City or Town, State Landover, MD.		
21. Signature of Funeral Service Licensee <i>[Signature]</i>		22. Name and Address of Facility Marshall's Funeral Home 4217 9th. St. N.W. Washington, D.C. 20011						
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Congestive Heart failure Coronary artery disease								
23b. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								
23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify)								
23d. Date of delivery Month: Day: Year:								
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								
26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)								
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined								
28a. Date of Injury (Month, Day, Year)								
28b. Time of Injury M								
28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								
28d. Describe how injury occurred								
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)								
28f. Location (Street and Number or Rural Route Number, City or Town, State)								
29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
29b. Signature and title of certifier <i>[Signature]</i>								
29c. License number D28920								
29d. Date signed (Month, Day, Year) 1/16/2004								
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Surinder Singh 7319A Hanover Parkway Greenbelt MD, 20770								
31. Date filed (Month, Day, Year) JAN 23 2004								
32. Registrar's Signature <i>[Signature]</i>								

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

1- For State Registrar

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Eileen McKenna Evans

2. Date of Death

January 19 2004

3. Time of Death

1605 p M

4a. Facility Name (If not institution, give street and number)

Suburban Hospital

4b. City, Town, or Location of Death

Bethesda

4c. County of Death

Montgomery

Funeral
Director

5. Social Security Number

152.38.6058

6. Sex

1 ☐ M ☒ F

7. Age (In yrs. last birthday)

57

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth (Month, Day, Year)

Sept. 18, 1946

9. Birthplace (State or Foreign Country)

New Jersey

Usual Residence of Decedent

10a. State

DC

10b. County

10c. City, Town or Location

Washington

10d. Inside City Limits

1 ☐ Yes ☒ No

10e. Street and Number

3900 Cathedral Avenue, N.W.

10f. Zip Code

20016

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4or 5+)

+4

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Executive Director

16b. Kind of Business/Industry

Phi Beta Delta Honor Society for International Scholars, Inc.

17. Father's Name (First, Middle, Last)

Francis McKenna

18. Mother's Name (First, Middle, Maiden Surname)

Margaret Cadien

19a. Informant's Name/Relationship (Type, Print)

William Evans, Jr./Husband

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

3900 Cathedral Avenue, N.W. Washington DC 20016

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Memorial Park

Date

Jan. 24, 2004

20c. Location - City or Town, State

Memphis, Tennessee

21. Signature of Funeral Service Licensee

[Signature]

22. Name and Address of Facility

Joseph Gawler's Sons, Inc.
5130 Wisconsin Avenue, N.W. Washington DC 20016

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Head injuries

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☒ No
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy
4 ☐ Pregnant at time of death 5 ☐ Other (specify)
9 ☐ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☒ Yes 2 ☐ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☒ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☒ Yes 2 ☐ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☒ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural 2 ☒ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

11/19/04

28b. Time of Injury

15:18

28c. Injury at Work?

1 ☐ Yes 2 ☒ No

28d. Describe how injury occurred

Pedestrian struck by a car

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

street

28f. Location (Street and Number or Rural Route Number, City or Town, State)

5100 Wisconsin Ave, Bethesda, Md

29a. Certifier (Check only one)

1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

[Signature]

29c. License number

OCME

29d. Date signed (Month, Day, Year)

January 21 2004

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2931414141 AL

111 Penn Street, Baltimore, Maryland 21201

31. Date filed (Month, Day, Year)

JAN 22 2004

32. Registrar's Signature

[Signature]

State
Registrar

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2004 03813

1- For
State
Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Nelson Wayne Elgin				2. Date of Death Month January Day 15 Year 2004		3. Time of Death 1:00 A M	
	4a. Facility Name (If not institution, give street and number) Shady Grove Adventist Nursing Home				4b. City, Town, or Location of Death Rockville		4c. County of Death Montgomery	
Funeral Director	5. Social Security Number 217-32-0398		6. Sex 1 M 2 F		7. Age (In yrs. last birthday) 69 Yrs.		8. Date of Birth (Month, Day, Year) May 1, 1934	
	9. Birthplace (State or Foreign Country) Washington, DC		10a. State Maryland		10b. County Montgomery		10c. City, Town or Location Washington Grove	
To Be Completed by Funeral Director	10d. Inside City Limits 1 Yes 2 No		10e. Street and Number 12 Center Street		10f. Zip Code 20880		10g. Citizen of What Country? United States	
	11. Marital Status 1 X Never Married 2 Married 3 Widowed 4 Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Yes 2 No Specify:		14. Race - American Indian, Black, White, etc. Specify: White	
To Be Completed by Physician/Medical Examiner	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 4		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Probation Officer		16b. Kind of Business/Industry State of Maryland			
	17. Father's Name (First, Middle, Last) Nelson C. Elgin				18. Mother's Name (First, Middle, Maiden Surname) Atlee Wayne Wirgman			
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) Personal Earl C. Hill, Jr. /Rep.				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 860 South River Landing Rd. Edgewater, MD 21037			
	20a. Method of Disposition 1 Burial 2 X Cremation 3 Removal from State 4 Donation 5 Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Metropolitan Crematory		Date Jan. 15, 2004		20c. Location - City or Town, State Alexandria, Virginia	
To Be Completed by Physician/Medical Examiner	21. Signature of Funeral Service-Licenses 				22. Name and Address of Facility DeVol Funeral Home 10 E. Deer Park Dr. Gaithersburg, MD 20877			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. End Stage Heart Failure Due to (or as a consequence of): Advanced Cardiomyopathy Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last				Approximate Interval Between Onset and Death			
To Be Completed by Physician/Medical Examiner	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown		23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 4 Pregnant at time of death 9 Unknown		3 Ectopic pregnancy 5 Other (specify)		23d. Date of delivery Month Day Year	
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				23a. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown			
To Be Completed by Physician/Medical Examiner	24a. Was an autopsy performed? 1 Yes 2 No		24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No		25. Was case referred to medical examiner? 1 Yes 2 No			
	26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify)		27. Manner of Death 1 Natural 2 Accident 3 Suicide 4 Homicide 5 Pending investigation 6 Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M	
To Be Completed by Physician/Medical Examiner	28c. Injury at Work? 1 Yes 2 No		28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			
	28f. Location (Street and Number or Rural Route Number, City or Town, State)		29a. Certifier (Check only one) 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.					
To Be Completed by Physician/Medical Examiner	29b. Signature and title of certifier 		29c. License number MD 58977		29d. Date signed (Month, Day, Year) 01/15/04			
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Shahryar Davor, MD 8609 2nd Ave Silver Spring, MD # Suite 404 B 20910		31. Date filed (Month, Day, Year) JAN 20 2004					
State Registrar	32. Registrar's Signature 		33. Registrar's Title Registrar					

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2004 03814

1- For
State
RegistrarPhysician
/Medical
ExaminerFuneral
Director

1. Decedent's Name (First, Middle, Last)

ELAINE PATRICIA ELAM

2. Date of Death

JANUARY 18, 2004

3. Time of Death

9:50 P M

4a. Facility Name (If not institution, give street and number)

BROOKE GROVE REHAB. & NURSING CENTER

4b. City, Town, or Location of Death

SANDY SPRING

4c. County of Death

MONTGOMERY

5. Social Security Number

579 28 7901

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

81

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth (Month, Day, Year)

Jan. 27 1922

9. Birthplace (State or Foreign Country)

Washington, D.C.

Usual Residence of Decedent

10a. State

Md.

10b. County

Montgomery

10c. City, Town or Location

Olney

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

17837 Whimsey Court

10f. Zip Code

20832

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

To Be Completed by Funeral Director

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

3

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

Raymond Hart

18. Mother's Name (First, Middle, Maiden Surname)

Annabelle Ryan

19a. Informant's Name/Relationship (Type, Print)

James W. Elam / Husband

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

17837 Whimsey Court, Olney, Maryland 20832

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

All Souls Cemetery

Date

1/24/04

20c. Location - City or Town, State

Germantown, Md.

21. Signature of Funeral Service Licensee

Murriel H. Barber

22. Name and Address of Facility

Murriel H. Barber Funeral Home
P. O. Box 5038, Laytonsville, Md. 20882

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Pneumonia

Approximate Interval Between Onset and Death

days

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

- a. Due to (or as a consequence of):
- b. Due to (or as a consequence of):
- c. Due to (or as a consequence of):
- d. Due to (or as a consequence of):

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☒ No
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy
4 ☐ Pregnant at time of death 5 ☐ Other (specify)
9 ☐ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation
2 ☐ Accident 6 ☐ Could not be determined
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Alok Mathur Physician

29c. License number

D0055694

29d. Date signed (Month, Day, Year)

January 19, 2004

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Alok Mathur 4000 Olney-Laytonsville Rd Olney, MD 20832

31. Date filed (Month, Day, Year)

JAN 20 2004

32. Registrar's Signature

Jennifer S. Sparks

State
Registrar

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2004 03815

1- For
State
Registrar

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Physician
/Medical
ExaminerFuneral
Director

1. Decedent's Name (First, Middle, Last) LUDMILA EGOENKOV		2. Date of Death Month Day Year JAN. 22, 2004		3. Time of Death 3:13 AM	
4a. Facility Name (If not institution, give street and number) Casey House		4b. City, Town, or Location of Death Rockville		4c. County of Death Montgomery	
5. Social Security Number 220-49-1287	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 32 Yrs.	8. Date of Birth (Month, Day, Year) Jan 30, 1971	9. Birthplace (State or Foreign Country) Kazakhstan	
Usual Residence of Decedent					
10a. State MD	10b. County Montgomery	10c. City, Town or Location Gaithersburg		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
10e. Street and Number 397 West Side Drive #202		10f. Zip Code 20877		10g. Citizen of What Country? U.S.A.	
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:	
14. Race - American Indian, Black, White, etc. Specify: White		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 4 College (1-4or 5+) 4			
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Pharmacist		16b. Kind of Business/Industry Shady Grove Adv. Hospital			
17. Father's Name (First, Middle, Last) Vladimir Maslov			18. Mother's Name (First, Middle, Maiden Surname) Galina Maslova		
19a. Informant's Name/Relationship (Type, Print) Veronika Federov-gaurdian			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 17116 Downing St Gaithersburg, MD 20877		
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Parklawn Mem. Park		20c. Location - City or Town, State 1/24/2004 Rockville, MD	
21. Signature of Funeral Service License 		22. Name and Address of Facility Snowden Funeral Home, PA 246 N Washington St Rockville, MD 20850			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) METASTATIC CARCINOMA					
23b. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Ovarian Cyst					
23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify)					
23d. Date of delivery Month Day Year					
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) Hospice					
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M	
28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred			
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.					
29b. Signature and title of certifier 		29c. License number D09470		29d. Date signed (Month, Day, Year) 1/22/2004	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Eugene P. Libre, MD 10400 Connecticut Ave Kensington, MD 20885					
31. Date filed (Month, Day, Year) JAN 23 2004		32. Registrar's Signature 			

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

Physician
/Medical
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

1- For
State
Registrar

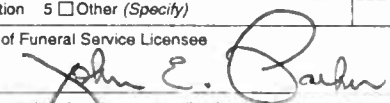

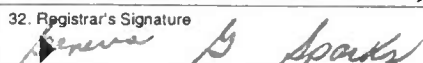
Please Type or Print in Indellible Ink. Ensure All Copies are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2004 03816

1. Decedent's Name (First, Middle, Last) Margaret Antonia Edwards		2. Date of Death Month January Day 18 Year 2004		3. Time of Death 4:15 P M	
4a. Facility Name (If not institution, give street and number) 13906 Shannon Drive		4b. City, Town, or Location of Death Silver Spring		4c. County of Death Montgomery	
5. Social Security Number 031-10-3475		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 90 Yrs.	
8. Date of Birth (Month, Day, Year) June 10, 1913		9. Birthplace (State or Foreign Country) Montana			
Usual Residence of Decedent					
10a. State Maryland		10b. County Montgomery		10c. City, Town or Location Silver Spring	
10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
10e. Street and Number 13906 Shannon Drive		10f. Zip Code 20904		10g. Citizen of What Country? USA	
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: 1944-46		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:	
14. Race - American Indian, Black, White, etc. Specify: White					
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 5+ College (1-4or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Physical Therapist		16b. Kind of Business/Industry Health Care	
17. Father's Name (First, Middle, Last) Anton Johnson		18. Mother's Name (First, Middle, Maiden Surname) Magdalen Gonsior			
19a. Informant's Name/Relationship (Type, Print) Helen A. Edwards/ Daughter		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 13906 Shannon Drive, Silver Spring, MD 20904			
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Arlington National Cemetery		20c. Location - City or Town, State February 18 2004 Arlington, Virginia	
21. Signature of Funeral Service Licensee 		22. Name and Address of Facility Francis J. Collins Funeral Home Inc. 500 University Blvd. W., Silver Spring, MD 20901			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Ovarian Cancer Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of):		23b. If FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown 23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Other (specify) <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Unknown		23d. Date of delivery Month Day Year	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Dementia		23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown			
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M	
28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred			
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.					
29b. Signature and title of certifier 		29c. License number D38262		29d. Date signed (Month, Day, Year) January 19, 2004	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr. A. Mendhiratta 2401 Research Blvd. #330, Rockville, MD 20850					
31. Date filed (Month, Day, Year) JAN 22 2004		32. Registrar's Signature 			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend Item #1 per me G829 3/11/04 tas

State of Maryland / Department of Health and Mental Hygiene

1- For Amend Item #1
State Registrar Unpend Item #23a, Part II, 27, Per ME, Certificate of Death

Reg. No. 2004 03817

3134

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

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To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Physician
/Medical
Examiner

Funeral
Director

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

1. Decedent's Name (First, Middle, Last) Reginald Devone Edge II Reginald Devone Edge, II Reginald Edge		2. Date of Death Month Day Year JANUARY 15, 2004		3. Time of Death 2316 P M	
4a. Facility Name (If not institution, give street and number) EASTON MEMORIAL HOSPITAL		4b. City, Town, or Location of Death EASTON		4c. County of Death TALBOT	
5. Social Security Number 230-53-4698	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 18 Yrs.	8. Date of Birth (Month, Day, Year) Sept, 18, 1985		9. Birthplace (State or Foreign Country) VA
Usual Residence of Decedent					
10a. State VA		10b. County Prince William		10c. City, Town or Location Manassas	
10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
10e. Street and Number 8402 Aubrey Drive		10f. Zip Code 20111		10g. Citizen of What Country? USA	
11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:	
14. Race - American Indian, Black, White, etc. Specify: Black					
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 5 College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Student		16b. Kind of Business/Industry Special Needs School	
17. Father's Name (First, Middle, Last) Reginald Devone Edge		18. Mother's Name (First, Middle, Maiden Surname) Toni Noreen Anderson			
19a. Informant's Name/Relationship (Type, Print) Reginald D. Edge, Father		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8402 Aubrey Drive, Manassas, Va. 20111			
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Quantico Nat. Cem.		20c. Location - City or Town, State 01-22-2004 Tringle, Va. 22172	
21. Signature of Funeral Service Licensee Bernard O. Ames		22. Name and Address of Facility Ames Funeral Home, Inc. 8914 Quarry Rd. Manassas, Va. 20110			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Acute Bronchopneumonia Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		23b. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <input type="checkbox"/> Unknown		23c. Date of delivery Month Day Year	
23d. Date of delivery Month Day Year					
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Seizure Disorder due to Sotos Syndrome		23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown			
24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No			
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input checked="" type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M	
28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred			
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier Tasha Z Greenberg MD		29c. License number OCME	
29d. Date signed (Month, Day, Year) JANUARY 16, 2004					
30. Name and address of person who completed cause of death (Item 23) (Type, Print) Tasha Z Greenberg M.D. 111 Penn Street, Baltimore, Maryland 21201					
31. Date filed (Month, Day, Year) JAN 20 2004		32. Registrar's Signature Sparks			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene **2004 03818**
Certificate of Death Reg. No.

1- For State Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) JESSE JAMES ENGLISH				2. Date of Death Month January Day 16 Year 2004		3. Time of Death 1250 M	
	4a. Facility Name (If not institution, give street and number) 2526 Iverson Street				4b. City, Town, or Location of Death Temple Hills		4c. County of Death Prince George's	
Funeral Director	5. Social Security Number 103-34-3891		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 62 Yrs.		8. Date of Birth (Month, Day, Year) October 12, 1941	
							9. Birthplace (State or Foreign Country) Virginia	
To Be Completed by Funeral Director	Usual Residence of Decedent							
	10a. State MD		10b. County Prince George's		10c. City, Town or Location Hillcrest			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
	10e. Street and Number 2526 Iverson Street				10f. Zip Code 20748		10g. Citizen of What Country? USA	
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: Black	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Policeman		16b. Kind of Business/Industry New York City Police Dept.	
	17. Father's Name (First, Middle, Last) Jesse James Jones				18. Mother's Name (First, Middle, Maiden Surname) Minnie R. English			
	19a. Informant's Name/Relationship (Type, Print) Contessa Simmons/Friend				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 240 Madison Street #4D New York, NY 10002			
	20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Riverdale Park Crematory		Date 1/24/2004		20c. Location - City or Town, State Riverdale, MD	
	21. Signature of Funeral Service Licensee John A. Bollen				22. Name and Address of Facility Cedar Hill Funeral Home, Inc. 4111 Pennsylvania Ave. Suitland, MD 20746			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Atherosclerotic Cardiovascular Heart Disease Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d.							
23b. IF FEMALE: Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown 23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <input type="checkbox"/> Unknown								
23d. Date of delivery Month Day Year								
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								
23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown								
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No								
26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)								
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide								
28a. Date of Injury (Month, Day Year)				28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28d. Describe how injury occurred				
28f. Location (Street and Number or Rural Route Number, City or Town, State)								
29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
29b. Signature and title of certifier Salvador Sylvestre				29c. License number 140053927		29d. Date signed (Month, Day, Year) January 17, 2004		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Salvador Sylvestre, 3001 Hospital Drive, Chesley, Maryland								
31. Date filed (Month, Day, Year) JAN 22 2004				32. Registrar's Signature Kevin K. Sparks				

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
 To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
 Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

ORIGINAL

1- For
State
Registrar

Unpend Item#23a, 27, Per ME, 6828, 2/13/04

Certificate of Death

Reg. No.

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transitPhysician
/Medical
ExaminerFuneral
Director

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last) Jeffrey Ricardo Eubanks		2. Date of Death Month January Day 20 Year 2004		3. Time of Death 1158 A.M.	
4a. Facility Name (If not institution, give street and number) 8231 - 14th Avenue, Apartment 301		4b. City, Town, or Location of Death Hyattsville		4c. County of Death Prince George's	
5. Social Security Number 219-94-4207		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 39 Yrs.	
8. Date of Birth (Month, Day, Year) Aug. 27, 1964		9. Birthplace (State or Foreign Country) Wash., DC			
Usual Residence of Decedent		10a. State Maryland		10b. County Prince George's	
10c. City, Town or Location Hyattsville		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No			
10e. Street and Number 8231 - 14th Ave., #301		10f. Zip Code 20783		10g. Citizen of What Country? United States	
11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:	
14. Race - American Indian, Black, White, etc. African American		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 2 College (1-4or 5+) 2		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Student	
16b. Kind of Business/Industry None		17. Father's Name (First, Middle, Last) James Louis Eubanks, Jr.		18. Mother's Name (First, Middle, Maiden Surname) Eunice Bray	
19a. Informant's Name/Relationship (Type, Print) James L. Eubanks, Jr.-Father		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1013 West Nolcrest Dr., Silver Spring, MD 20903			
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Park		20c. Location - City or Town, State Laurel, MD	
21. Signature of Funeral Service Licensee John T. Stewart III		22. Name and Address of Facility Stewart Funeral Home 4001 Benning Rd., N.E. Wash., DC 20019			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Acute Bronchopneumonia		Approximate Interval Between Onset and Death			
23b. Immediately list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		a. Due to (or as a consequence of):			
		b. Due to (or as a consequence of):			
		c. Due to (or as a consequence of):			
		d. Due to (or as a consequence of):			
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify)		23d. Date of delivery Month Day Year	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown			
24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No			
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M	
28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred			
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier Tasha Z Greenberg MD		29c. License number O.C.M.E.	
29d. Date signed (Month, Day, Year) January 21, 2004					
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Tasha Z Greenberg M.D.		111 Penn Street, Baltimore, Maryland 21201			
31. Date filed (Month, Day, Year) JAN 30 2004		32. Registrar's Signature John T. Stewart III			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For
State
Registrar

Certificate of Death

Reg. No.

2004 03820

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Alma W. Foster				2. Date of Death Month Day Year January 19 2004				3. Time of Death 12:55AM			
	4a. Facility Name (If not institution, give street and number) Shady Grove Adventist Hospital				4b. City, Town, or Location of Death Rockville				4c. County of Death Montgomery			
Funeral Director	5. Social Security Number 215-66-7661		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 87 Yrs.		8. Date of Birth (Month, Day, Year) Jan. 21, 1916		9. Birthplace (State or Foreign Country) Washington, D.C.			
	10a. State Maryland				10b. County Montgomery		10c. City, Town or Location Derwood				10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
To Be Completed by Funeral Director	10e. Street and Number 16608 Briardale Road				10f. Zip Code 20855				10g. Citizen of What Country? United States			
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: White			
To Be Completed by Physician/Medical Examiner	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker				16b. Kind of Business/Industry Own Home			
	17. Father's Name (First, Middle, Last) Wilhelm Schmidt				18. Mother's Name (First, Middle, Maiden Surname) Johanna Leiding							
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) Joanne B. Ward/Niece				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 610 Coconut Palm Road, Vero Beach, Florida 32963							
	20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Montgomery Crematorium		Date January 22, 2004		20c. Location - City or Town, State Bethesda, Maryland					
To Be Completed by Physician/Medical Examiner	21. Signature of Funeral Service Licensee Ray [Signature] M00198				22. Name and Address of Facility Robert A. Pumphrey Funeral Home/ Bethesda-Chevy Chase, Inc. 7557 Wisconsin Ave., Bethesda, MD 20814-3501							
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last a. urosepsis (Escherichia coli) Due to (or as a consequence of): b. acute renal failure Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of):				Approximate Interval Between Onset and Death days days							
To Be Completed by Physician/Medical Examiner	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <input type="checkbox"/> Unknown		23d. Date of delivery Month Day Year							
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Dementia Alzheimers High Blood Pressure Asthma				23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown							
To Be Completed by Physician/Medical Examiner	24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No									
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)									
To Be Completed by Physician/Medical Examiner	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred			
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)									
To Be Completed by Physician/Medical Examiner	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				29b. Signature and title of certifier Eric Brodsky MD				29c. License number 054299			
	29d. Date signed (Month, Day, Year) January 19, 2004											
To Be Completed by Physician/Medical Examiner	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Eric Brodsky 9901 Medical Center Drive Rockville, MD											
	31. Date filed (Month, Day, Year) JAN 22 2004		32. Registrar's Signature [Signature]									

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar AMEND#29 per MD1/29/04, BW, McC

Certificate of Death

Reg. No.

2004 03821

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Frank Joseph Formeller				2. Date of Death Month January Day 19 Year 2004		3. Time of Death 4:34 p^M	
	4a. Facility Name (If not institution, give street and number) Montgomery Hospice- Casey House				4b. City, Town, or Location of Death Rockville		4c. County of Death Montgomery	
Funeral Director	5. Social Security Number 342-24-0483		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 73 Yrs.		8. Date of Birth (Month, Day, Year) May 21, 1930	
	9. Birthplace (State or Foreign Country) Illinois		10a. State Maryland		10b. County Montgomery		10c. City, Town or Location Silver Spring	
To Be Completed by Funeral Director	10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		10e. Street and Number 14217 Georgia Avenue, Apt. T-1		10f. Zip Code 20906		10g. Citizen of What Country? USA	
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: 1956-77		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White	
To Be Completed by Physician/Medical Examiner	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 5+		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Physiologist		16b. Kind of Business/Industry U.S. Navy		17. Father's Name (First, Middle, Last) Florian J. Formeller	
	18. Mother's Name (First, Middle, Maiden Surname) Kathryn McGuire		19a. Informant's Name/Relationship (Type, Print) John J. Formeller/ Son		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19033 Partridge Wood Drive, Germantown, MD 20874		20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)	
To Be Completed by Physician/Medical Examiner	20b. Place of Disposition (Name of cemetery, crematory or other place) Arlington National Cemetery		20c. Location - City or Town, State Arlington, Virginia		20d. Date February 3 2004		21. Signature of Funeral Service Licensee 	
	22. Name and Address of Facility Francis J. Collins Funeral Home Inc. 500 University Blvd. W., Silver Spring, MD 20901		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. a. Mesothelioma Due to (or as a consequence of):		Approximate Interval Between Onset and Death Months		23b. If FEMALE: Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown	
To Be Completed by Physician/Medical Examiner	23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify)		23d. Date of delivery Month Day Year		23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) Hospice		27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined	
To Be Completed by Physician/Medical Examiner	28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred	
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)		29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier 	
To Be Completed by Physician/Medical Examiner	29c. License number D35635		29d. Date signed (Month, Day, Year) January 20, 2004		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Joseph Kaplan M.D. 6001 Muncaster Mill Road, Rockville, MD 20855		31. Date filed (Month, Day, Year) JAN 22 2004	
	32. Registrar's Signature 		33. State Registrar State Registrar		34. Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036		35. To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.



State of Maryland / Department of Health and Mental Hygiene

2004 03822

1- For
State
Registrar

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Irving Foote				2. Date of Death Month January Day 17 , Year 2004				3. Time of Death 1:20 A M	
	4a. Facility Name (If not institution, give street and number) 3603 Parkington Lane				4b. City, Town, or Location of Death Silver Spring				4c. County of Death Montgomery	
Funeral Director	5. Social Security Number 297-09-8506		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 84 Yrs.		8. Date of Birth (Month, Day, Year) May 29, 1919		9. Birthplace (State or Foreign Country) Ohio	
	Usual Residence of Decedent				10a. State Maryland		10b. County Montgomery		10c. City, Town or Location Silver Spring	
To Be Completed by Funeral Director	10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No				10e. Street and Number 3603 Parkington Lane				10f. Zip Code 20906	
	10g. Citizen of What Country? USA				11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced				12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: WWII	
To Be Completed by Physician/Medical Examiner	13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: White				15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12)	
	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Management Analyst				16b. Kind of Business/Industry U.S. Navy				17. Father's Name (First, Middle, Last) Earl Foote	
To Be Completed by Physician/Medical Examiner	18. Mother's Name (First, Middle, Maiden Surname) Dorothy Budde				19a. Informant's Name/Relationship (Type, Print) Iverna Foote- Spouse				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3603 Parkington Lane Silver Spring, MD 20906	
	20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Loudon Park Crematory				20c. Location - City or Town, State Baltimore, MD	
To Be Completed by Physician/Medical Examiner	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility Hines-Rinaldi Funeral Home 11800 New Hampshire Ave. Silver Spring, MD 20904				23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Sudden Cardiac Death	
	23b. Immediate Cause (Final disease or condition resulting in death) Sudden Cardiac Death				23c. Due to (or as a consequence of): Dilated Cardiomyopathy-Ischemic				Approximate Interval Between Onset and Death Immediately	
To Be Completed by Physician/Medical Examiner	23d. Due to (or as a consequence of): Pulmonary Fibrosis				23e. Due to (or as a consequence of):				Approximate Interval Between Onset and Death 7 Years	
	23f. Due to (or as a consequence of):				23g. Due to (or as a consequence of):				Approximate Interval Between Onset and Death 2 Years	
To Be Completed by Physician/Medical Examiner	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown				23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify)				23d. Date of delivery Month _____ Day _____ Year _____	
	23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown				24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)				27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined	
	28a. Date of Injury (Month, Day, Year)				28b. Time of Injury M				28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
To Be Completed by Physician/Medical Examiner	28d. Describe how injury occurred				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)	
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				29b. Signature and title of certifier 				29c. License number D3045	
To Be Completed by Physician/Medical Examiner	29d. Date signed (Month, Day, Year) January 17, 2004				30. Name and address of person who completed cause of death (Item 23a) (Type, Print) P. Henjum, M.D. 3416 Olandwood Ct. #204 Olney, MD 20832				31. Date filed (Month, Day, Year) JAN 22 2004	
	32. Registrar's Signature 				33. State Registrar 10				34. Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2004 03823

1- For State Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Lyle C. Farmer				2. Date of Death Month Day Year January 17, 2004		3. Time of Death 10:00 PM	
	4a. Facility Name (If not institution, give street and number) Renaissance Gardens at Riderwood Village				4b. City, Town, or Location of Death Silver Spring		4c. County of Death Montgomery	
Funeral Director	5. Social Security Number 304-28-7425		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 89 Yrs.		8. Date of Birth (Month, Day, Year) Nov. 4, 1914	
	9. Birthplace (State or Foreign Country) North Dakota		10a. State Maryland		10b. County Montgomery		10c. City, Town or Location Silver Spring	
To Be Completed by Funeral Director	10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				10e. Street and Number 3610 Gracefield Road, KC-417			
	10f. Zip Code 20904				10g. Citizen of What Country? USA			
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: 1942-45		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <input type="checkbox"/> College (1-4 or 5+) <input checked="" type="checkbox"/> 5+		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Administrative Law Judge		16b. Kind of Business/Industry Federal Government			
	17. Father's Name (First, Middle, Last) John Farmer				18. Mother's Name (First, Middle, Maiden Surname) Anne Louise McCannel			
	19a. Informant's Name/Relationship (Type, Print) Lyle Michael Farmer/ Son				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9707 Stoneybrook Drive, Kensington, MD 20895			
	20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Metropolitan Crematory		20c. Location - City or Town, State Alexandria, Virginia		20d. Date January 19, 2004	
	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility Francis J. Collins Funeral Home Inc. 500 University Blvd. W., Silver Spring, MD 20901			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Urosepsis Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of):							
	23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown							
23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Other (specify) <input checked="" type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Unknown								
23d. Date of delivery Month Day Year								
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Macroglobulinemia								
23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown								
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								
26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)								
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
28d. Describe how injury occurred				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				
28f. Location (Street and Number or Rural Route Number, City or Town, State)								
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
29b. Signature and title of certifier 				29c. License number D34590		29d. Date signed (Month, Day, Year) January 19, 2004		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr. Roy Fried 3110 Gracefield Road, Silver Spring, MD 20906								
31. Date filed (Month, Day, Year) JAN 20 2004				32. Registrar's Signature 				

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2004 03824

1- For State Registrar

Physician /Medical Examiner

Funeral Director

1. Decedent's Name (First, Middle, Last) Pearl Ford				2. Date of Death Month Day Year January 14, 2004		3. Time of Death 3:15p. M	
4a. Facility Name (If not institution, give street and number) 12801 Hollins Place				4b. City, Town, or Location of Death Bowie		4c. County of Death Prince Georges	
5. Social Security Number 578 20 0943		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 82 Yrs.		8. Date of Birth (Month, Day, Year) March 6, 1921	
9. Birthplace (State or Foreign Country) Maryland		Usual Residence of Decedent					
10a. State MD		10b. County Prince Georges		10c. City, Town or Location Bowie		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
10e. Street and Number 12801 Hollins Place				10f. Zip Code 20716		10g. Citizen of What Country? United States	
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: Black	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 6th College (1-4or 5+) none				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Printer		16b. Kind of Business/Industry US Government	
17. Father's Name (First, Middle, Last) Charles Nightengale				18. Mother's Name (First, Middle, Maiden Surname) Martha P. Sydnor			
19a. Informant's Name/Relationship (Type, Print) Debra Spratley niece				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12801 Hollins Pl., Bowie, MD 20716			
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Harmony Memorial Cem.		Date 01/21/04		20c. Location - City or Town, State Landover, MD	
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility John T. Rhines Funeral Home 3015 12th St., NE Washington, DC 20017			

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Cardiorespiratory Arrest Due to (or as a consequence of): b. Lung Cancer Due to (or as a consequence of): c. Due to (or as a consequence of): d.				Approximate Interval Between Onset and Death 5 months	
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <input type="checkbox"/> Unknown		23d. Date of delivery Month Day Year	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown	
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year) M		28b. Time of Injury 1 Yes <input type="checkbox"/> No	
28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	
28f. Location (Street and Number or Rural Route Number, City or Town, State)		29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.			
29b. Signature and title of certifier 		29c. License number D0056791		29d. Date signed (Month, Day, Year) January 16, 2004	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr. Luis Gonzalez 1221 Mercantile Lane, Largo, Maryland					

State Registrar

JAN 21 2004

ORIGINAL

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene **2004 03825**

1- For State Registrar

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Estela A. Frechette		2. Date of Death Month Jan. Day 15 Year 2004		3. Time of Death 12:35 AM
	4a. Facility Name (If not institution, give street and number) National Lutheran Home		4b. City, Town, or Location of Death Rockville		4c. County of Death Montgomery
Funeral Director	5. Social Security Number 532-40-6214	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 94 Yrs.	8. Date of Birth (Month, Day, Year) May 1, 1909	
	9. Birthplace (State or Foreign Country) Chile				
To Be Completed by Funeral Director	10a. State Md.		10b. County Montgomery		10c. City, Town or Location Rockville
	10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No				
	10e. Street and Number 9701- Veirs Drive		10f. Zip Code 20850		10g. Citizen of What Country? USA
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:
	14. Race - American Indian, Black, White, etc. Specify: White				
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 4 yrs College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker		16b. Kind of Business/Industry At Home
	17. Father's Name (First, Middle, Last) Abel Reyes		18. Mother's Name (First, Middle, Maiden Surname) Dorila Rojas		
	19a. Informant's Name/Relationship (Type, Print) Myles Frechette - Son		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7204-Panorama Dr., Derwood, Md. 20855		
	20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Metropolitan Crematory-1/17/04-Alexandria, Va.		Date
	20c. Location - City or Town, State				
21. Signature of Funeral Service Licensee W. M. Hysong		22. Name and Address of Facility Hysong Co., Inc. 6510-16th St., NW, Wash., DC			
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of death.				Approximate Interval Between Onset and Death 1 week 2 weeks 2 weeks
	Immediate Cause (Final disease or condition resulting in death) Respiratory failure				
	Due to (or as a consequence of): Congestive heart failure				
	Due to (or as a consequence of): pneumonia				
	Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last				
	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown				23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Other (specify)
	23d. Date of delivery Month Day Year				
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. History of cerebral vascular accident Advanced Alzheimer's disease				
	23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown				
	24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M	
28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred			
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier Charles W. Karesh		29c. License number D21726	
29d. Date signed (Month, Day, Year) January 16, 2004		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr. Charles W. Karesh- 9701-Veirs Dr., Rockville, Md. 20850			
31. Date filed (Month, Day, Year) JAN 21 2004		Registrar's Signature John A. Smith			

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2004 03826

1- For
State
RegistrarPhysician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Florence Elizabeth McHale Fenton

2. Date of Death

January 21 2004

3. Time of Death

12:20P M

4a. Facility Name (If not institution, give street and number)

2538 Rutland Road

4b. City, Town, or Location of Death

Davidsonville

4c. County of Death

Anne Arundel

Funeral
Director

5. Social Security Number

169-28-7837

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

76 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Dec. 19, 1927

9. Birthplace (State or Foreign Country)

Pennsylvania

Usual Residence of Decedent

10a. State

MD

10b. County

Anne Arundel

10c. City, Town or Location

Davidsonville

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

2538 Rutland Road

10f. Zip Code

21035

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: White

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

5+

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Teacher

16b. Kind of Business/Industry

Public Schools

17. Father's Name (First, Middle, Last)

Michael McHale

18. Mother's Name (First, Middle, Maiden Surname)

Blanch White

19a. Informant's Name/Relationship (Type, Print)

Brian K. Fenton / Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2538 Rutland Rd. Davidsonville, MD. 21035

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

MD. Veterans Cemetery

Date

1-28-2004

20c. Location - City or Town, State

Cheltenham, MD.

21. Signature of Funeral Service Licensee

E. Brian Powell

22. Name and Address of Facility

Beall Funeral Home

6512 NW Crain Highway Bowie, MD. 20715

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

Congestive Heart Failure

Approximate
Interval Between
Onset and Death

2 days

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

a. Due to (or as a consequence of):

Polycythemia

1996

b. Due to (or as a consequence of):

Alzheimer's

1995

c. Due to (or as a consequence of):

IF FEMALE:

23b. Was decedent pregnant
in the past 12 months?
1 ☐ Yes 2 ☒ No
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy
4 ☐ Pregnant at time of death 5 ☐ Other (specify)
9 ☐ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an
autopsy
performed?
1 ☐ Yes 2 ☒ No24b. Were autopsy findings available
prior to completion of cause of
death?
1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?
1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending
investigation
2 ☐ Accident 6 ☐ Could not be
determined
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury

(Month, Day Year)

28b. Time of
Injury

M

28c. Injury at
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
and manner stated.

29b. Signature and title of certifier

E. Brian Powell MD

29c. License number

D26199

29d. Date signed (Month, Day, Year)

January 21, 2004

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Emily Ulmer, M.D. 2191 Defense Hwy. Suite 201 Crofton, MD. 21114

31. Date filed (Month, Day, Year)

JAN 22 2004

32. Registrar's Signature

Brian K. Fenton

State
Registrar

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show
any injury or other traumatic event, the Medical Examiner must be notified at
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Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show
any injury or other traumatic event, the Medical Examiner must be notified at
once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2004 03827

1- For
State
RegistrarPhysician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

JOYCE MARIE FRAZIER

2. Date of Death

Month

Day

3. Time of Death

January

17,

2004

2:00 PM

Funeral
Director

4a. Facility Name (If not institution, give street and number)

Heartland Health Care Center

4b. City, Town, or Location of Death

Adelphi

4c. County of Death

Prince George

5. Social Security Number

579-54-8905

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

62

Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

(Month, Day, Year)

July 2, 1941

9. Birthplace (State or Foreign Country)

D.C.

Usual Residence of Decedent

10a. State

DC

10b. County

10c. City, Town or Location

Washington

10d. Inside City Limits

☒ Yes 2 ☐ No

10e. Street and Number

461 H Street, NW

10f. Zip Code

20001

10g. Citizen of What Country?

USA

11. Marital Status

1 ☒ Never Married 2 ☐ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give

Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: Black

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

Housekeeping

16b. Kind of Business/Industry

Mayflower

17. Father's Name (First, Middle, Last)

Douglas Frazier

18. Mother's Name (First, Middle, Maiden Surname)

Mildred Banks

19a. Informant's Name/Relationship (Type, Print)

Angela Long/Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

5703 18th Ave, Hyattsville, MD 20782

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Glenwood Cemetery

Date

1/22/04

20c. Location - City or Town, State

Washington, DC

21. Signature of Funeral Service Licensee

Eric R. Strickland

22. Name and Address of Facility

Strickland Funeral Services

6500 Allentown Rd, Camp Springs, MD 20748

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Atherosclerotic cardiovascular disease

Due to (or as a consequence of):

b. Diabetes mellitus

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Approximate Interval Between Onset and Death

IF FEMALE:

23b. Was decedent pregnant

in the past 12 months?

1 ☐ Yes 2 ☐ No9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death4 ☐ Pregnant at time of death9 ☐ Unknown3 ☐ Ectopic pregnancy5 ☐ Other (specify)

23d. Date of delivery

Month

Day

Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

End stage Renal disease

Hypertension

Peripheral vascular disease

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an

autopsy

performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available

prior to completion of cause of

death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical

examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending

investigation

6 ☐ Could not be

determined

28a. Date of Injury

(Month, Day, Year)

28b. Time of

Injury

28c. Injury at

Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier

(Check only one)

1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Eric R. Strickland

29c. License number

D42403

29d. Date signed (Month, Day, Year)

1-22-04

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Reo Moore MD 106 Irving St. N.W. Sk. 218 Washi, DC 20010

31. Date filed (Month, Day, Year)

JAN 23 2004

32. Registrar's Signature

Eric R. Strickland

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

State
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2004 03828

1- For State Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) HELEN L. GUTTERMAN				2. Date of Death Month Day Year JAN 16, 2004		3. Time of Death 4:05A M	
	4a. Facility Name (If not institution, give street and number) ROCKVILLE NURSING HOME				4b. City, Town, or Location of Death ROCKVILLE		4c. County of Death MONTGOMERY	
Funeral Director	5. Social Security Number 452-03-8549		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 93 Yrs.		8. Date of Birth (Month, Day, Year) 10/29/1910	
	9. Birthplace (State or Foreign Country) NEW YORK							
To Be Completed by Funeral Director	Usual Residence of Decedent							
	10a. State MARYLAND		10b. County MONTGOMERY		10c. City, Town or Location ROCKVILLE			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
	10e. Street and Number 303 ADCLARE ROAD				10f. Zip Code 20850		10g. Citizen of What Country? U.S.A.	
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: WHITE	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 1 College (1-4or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) ADMINISTRATIVE ASSISTANT		16b. Kind of Business/Industry BUSINESS	
	17. Father's Name (First, Middle, Last) HARRY LIPTON				18. Mother's Name (First, Middle, Maiden Surname) NELLIE BERKOWITZ			
	19a. Informant's Name/Relationship (Type, Print) MARILYN G. TANENHOLTZ/DAUGHTER				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12304 OLD CANAL ROAD, POTOMAC, MARYLAND 20854			
	20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) NATIONAL CREMATORIUM		Date JAN 20, 2004		20c. Location - City or Town, State FALLS CHURCH, VIRGINIA	
	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility EDWARD SAGEL FUNERAL DIRECTION, INC. 1091 ROCKVILLE PIKE, ROCKVILLE, MARYLAND 20852			
	23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. CEREBROVASCULAR ACCIDENT Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Approximate Interval Between Onset and Death HOURS							
23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown								
23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Other (specify) <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Unknown								
23d. Date of delivery Month Day Year								
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. PNEUMONIA, CONGESTIVE HEART FAILURE, HYPERTENSION								
23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown								
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								
26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)								
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide								
28a. Date of Injury (Month, Day Year)								
28b. Time of Injury M								
28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								
28d. Describe how injury occurred								
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)								
28f. Location (Street and Number or Rural Route Number, City or Town, State)								
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.								
29b. Signature and title of certifier 								
29c. License number D0059499								
29d. Date signed (Month, Day, Year) JANUARY 16, 2004								
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DR. MARY CALLEN, 6000 EXECUTIVE BLVD, SUITE 300, ROCKVILLE, MARYLAND 20852								
31. Date filed (Month, Day, Year) JAN 22 2004								
32. Registrar's Signature 								

Baltimore, Maryland 21215-0036

perm. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural," or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

AMEND ITEM #10a-f PER FH G830 4/23/04 JR

Certificate of Death

Reg. No.

2004 03829

Physician /Medical Examiner

Funeral Director

1. Decedent's Name (First, Middle, Last) Alexander GROWER		2. Date of Death Month January Day 21 Year 2004		3. Time of Death 5:30 A M	
4a. Facility Name (If not institution, give street and number) 1316 Fenwick Lane #1409		4b. City, Town, or Location of Death Silver Spring		4c. County of Death Montgomery	
5. Social Security Number 041-32-7062		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 95 Yrs.	
8. Date of Birth (Month, Day, Year) Nov. 7, 1908		9. Birthplace (State or Foreign Country) Connecticut			
Usual Residence of Decedent					
10a. State FL		10b. County BREVARD		10c. City, Town or Location MELBOURNE	
10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		10e. Street and Number 1653 TIMBER WAY		10f. Zip Code 32935-5740	
10g. Citizen of What Country? United States		11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No WWII If Yes, Give Year or Dates: Korean	
13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: white			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 5+ College (1-4or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Dentist		16b. Kind of Business/Industry Dental	
17. Father's Name (First, Middle, Last) Louis Grower		18. Mother's Name (First, Middle, Maiden Surname) Annie Josephson			
19a. Informant's Name/Relationship (Type, Print) Marvin Grower, Son		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1615 Hugo Circle, Silver Spring, MD 20906			
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Arlington National Cemetery		20c. Location - City or Town, State Arlington, VA	
21. Signature of Funeral Service Licensee 		22. Name and Address of Facility Torchinsky Hebrew Funeral Home, Inc. 254 Carroll St., NW, Washington, DC 20012			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Coronary Artery Disease Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Congestive heart failure c. hypertension d. dementia					
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <input type="checkbox"/> Unknown		23d. Date of delivery Month 1 Day 22 Year 04	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Congestive heart failure hypertension dementia				23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown	
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M	
28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred			
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.					
29b. Signature and title of certifier 		29c. License number MD 11743		29d. Date signed (Month, Day, Year) 1/22/04	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) JAY WILDER MD Walter Reed Army Hosp. Wash, DC 20307					
31. Date filed (Month, Day, Year) JAN 22 2004		32. Registrar's Signature 			

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial/transit

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2004 03830

1- For State Registrar AMEND # 5 per INF1/29/04, BMW, McCo Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Philomena Grifone

2. Date of Death

January 14, 2004

3. Time of Death

4:40 P M

4a. Facility Name (If not institution, give street and number)

Montgomery Hospice-Casey House

4b. City, Town, or Location of Death

Rockville

4c. County of Death

Montgomery

Funeral
Director

5. Social Security Number

578-28-2902

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

77 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Aug. 19, 1926

9. Birthplace (State or Foreign Country)

Washington, DC

Usual Residence of Decedent

10a. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Silver Spring

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

3679 South Leisure World Blvd.

10f. Zip Code

20906

10g. Citizen of What Country?

USA

11. Marital Status

1 ☒ Never Married 2 ☐ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)
12

College (1-4or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Director of Eastern Cooperative Cancer Research Oncology Group

16b. Kind of Business/Industry

17. Father's Name (First, Middle, Last)

Michael Grifone

18. Mother's Name (First, Middle, Maiden Surname)

Carmela Albanese

19a. Informant's Name/Relationship (Type, Print)

Donna M. Cardano/ Niece

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1804 Judicial Way, Crofton, MD 21114

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Gate of Heaven Cemetery

Date

January 17 2004

20c. Location - City or Town, State

Silver Spring, MD

21. Signature of Funeral Service Licensee

Bradley J. Smith

22. Name and Address of Facility

Francis J. Collins Funeral Home Inc.
500 University Blvd. W., Silver Spring, MD 20901

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Metastatic Non-Hodgkins Lymphoma

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death
less than 6 months

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☐ No
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy
4 ☐ Pregnant at time of death 5 ☐ Other (specify)
9 ☐ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Anemia, Thrombocytopenia

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24e. Was an autopsy performed?
1 ☐ Yes 2 ☒ No24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No25. Was case referred to medical examiner?
1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☒ Other (Specify) Hospice

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Charles Harrison M.D.

29c. License number

00041218

29d. Date signed (Month, Day, Year)

1/15/04

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Charles Harrison M.D. 6001 Muncaster Mill Road, Rockville, MD 20855

31. Date filed (Month, Day, Year)

JAN 20 2004

32. Registrar's Signature

Sparks

Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2004 03831

1- For
State
RegistrarPhysician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

JASON GREEN

2. Date of Death

Month Day Year
JAN 09 2004

3. Time of Death

1310 M

4a. Facility Name (If not institution, give street and number)

HOWARD COUNTY GENERAL HOSPITAL

4b. City, Town, or Location of Death

COLUMBIA

4c. County of Death

HOWARD

Funeral
Director

5. Social Security Number

140-30-7248

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

64 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

11/25/1939

9. Birthplace (State or Foreign Country)

NEW JERSEY

Usual Residence of Decedent

10a. State

MARYLAND

10b. County

HOWARD

10c. City, Town or Location

ROCKY GORGE

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

8351 SAND CHERRY LANE

10f. Zip Code

20723

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: WHITE

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

6

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

INFORMATION SECURITY

16b. Kind of Business/Industry

DEPARTMENT OF DEFENSE

17. Father's Name (First, Middle, Last)

LOUIS SAMUEL GREEN

18. Mother's Name (First, Middle, Maiden Surname)

NATALIE FORGASH

19a. Informant's Name/Relationship (Type, Print)

LYNN KLEIN GREEN/WIFE

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

8351 SAND CHERRY LANE, ROCKY GORGE, MD 20723

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

JUDEAN MEM. GARDENS

Date

01/11/2004

20c. Location - City or Town, State

OLNEY, MARYLAND

21. Signature of Funeral Service Licensee

Donald C. Stottmeyer

22. Name and Address of Facility

DANZANSKY-GOLDBERG MEMORIAL CHAPELS, INC.
1170 ROCKVILLE PIKE, ROCKVILLE, MD 2085223a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

SEPTIC SHOCK

Approximate
Interval Between
Onset and Death

24 HOURS

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

a. Due to (or as a consequence of):

METASTATIC PANCREATIC CANCER

5 MONTHS

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

IF FEMALE:

23b. Was decedent pregnant
in the past 12 months?1 ☐ Yes 2 ☐ No
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 5 ☐ Other (specify)
9 ☐ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

DIABETES MELLITUS

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an
autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings available
prior to completion of cause of
death?1 ☐ Yes 2 ☒ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation
6 ☐ Could not be determined

28a. Date of Injury

(Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

David Nyamang

29c. License number

D36974

29d. Date signed (Month, Day, Year)

JAN 9 2004

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

10724 LITTLE PACIENT PARKWAY COLUMBIA MD 21044

DR. DAVID NYAMANG, M.D.

State
Registrar

31. Date filed (Month, Day, Year)

JAN 20 2004

32. Registrar's Signature

David Nyamang

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

pemit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural," or items 23a or 28a-f show
any injury or other traumatic event, the Medical Examiner must be notified at
once.Physician
/Medical
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2004 03832

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Physician / Medical Examiner

Funeral Director

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

1. Decedent's Name (First, Middle, Last) <i>Jacqueline Green</i>		2. Date of Death Month <i>Jan</i> Day <i>15</i> Year <i>2004</i>		3. Time of Death <i>1458PM</i>	
4a. Facility Name (If not institution, give street and number) <i>Lorien Nursing Home</i>		4b. City, Town, or Location of Death <i>Columbia</i>		4c. County of Death <i>Howard</i>	
5. Social Security Number <i>578-42-3366</i>	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <i>75</i> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <i>12/31/28</i>
9. Birthplace (State or Foreign Country) <i>Washington, DC</i>		Usual Residence of Decedent			
10a. State <i>MD</i>	10b. County <i>Howard</i>	10c. City, Town or Location <i>Columbia</i>		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
10e. Street and Number <i>6334 Cedar Lane</i>		10f. Zip Code <i>21044</i>		10g. Citizen of What Country? <i>United States</i>	
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:	
14. Race - American Indian, Black, White, etc. Specify: <i>Black</i>		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <i>12</i> College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <i>Seamstress</i>	
16b. Kind of Business/Industry <i>Private</i>		17. Father's Name (First, Middle, Last) <i>Sandy A. Levi</i>		18. Mother's Name (First, Middle, Maiden Surname) <i>Nellie Timmons</i>	
19a. Informant's Name/Relationship (Type, Print) <i>Travis Levi/Nephew</i>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>4808 Moorland Lane, #913, Bethesda, MD. 20814</i>			
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <i>Ft. Lincoln</i>		20c. Location - City or Town, State <i>1/20/04 Bladensburg, MD.</i>	
21. Signature of Funeral Service Licensee <i>Andre Thompson</i>		22. Name and Address of Facility <i>McGuire Funeral Service 7400 Georgia Avenue, NW, Wash. DC 20012</i>			
23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. <i>myocardial infarction</i> Due to (or as a consequence of): b. <i>coronary artery disease</i> Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last					
Approximate Interval Between Onset and Death <i>5 min</i> <i>10 yrs</i>					
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>respiratory failure</i> <i>dementia</i>					
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown					
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <i>M</i>	
28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred			
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.					
29b. Signature and title of certifier <i>[Signature]</i>		29c. License number <i>D41617</i>		29d. Date signed (Month, Day, Year) <i>Jan 15, 2004</i>	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <i>Gary Kaczmarek 10805 Hickory Ridge Rd Columbia, Md 21044</i>					
31. Date filed (Month, Day, Year) <i>JAN 23 2004</i>		32. Registrar's Signature <i>[Signature]</i>			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND#2 to MD1/30/04, BW, State of Maryland / Department of Health and Mental Hygiene

2004 03833

1- State AMEND#23 to MD1/23/04, BW, McCo Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Adele Grane

2. Date of Death 1-15-2004
Month Day Year
January 14 2004

3. Time of Death
1139 a M

4a. Facility Name (If not institution, give street and number)

Bon Secours Hospital

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

5. Social Security Number

578-52-0312

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

87 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

10/31/1916

9. Birthplace (State or Foreign Country)

WASHINGTON, DC

Usual Residence of Decedent

10a. State

MARYLAND

10b. County

MONTGOMERY

10c. City, Town or Location

KENSINGTON

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

10225 FREDERICK AVENUE #700

10f. Zip Code

20895

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☒ Never Married 2 ☐ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☒ Yes 2 ☐ No
If Yes, Give Year or Dates: "UNKNOWN"

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

2

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

"UNKNOWN"

16b. Kind of Business/Industry

FEDERAL GOVERNMENT

17. Father's Name (First, Middle, Last)

MORRIS ROBERT GRANE

18. Mother's Name (First, Middle, Maiden Surname)

SARAH SHAFER

19a. Informant's Name/Relationship (Type, Print)

CARLYLE M. RUBINOW/PERSONAL REP.

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

230 NORTH WASHINGTON ST, SUITE 400, ROCKVILLE, MD 0850

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

B'NAI ISRAEL CEMETERY

Date

01/28/2004

20c. Location - City or Town, State

OXON HILL, MARYLAND

21. Signature of Funeral Service Licensee

[Signature]

22. Name and Address of Facility

DANZANSKY-GOLDBERG MEMORIAL CHAPELS, INC.
1170 ROCKVILLE PIKE, ROCKVILLE, MARYLAND 20852

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Aspiration

a. ~~Dislodged tracheostomy tube~~
Due to (or as a consequence of):
Dislodged tracheostomy tube

b. ~~Aspiration~~
Due to (or as a consequence of):

c.
Due to (or as a consequence of):

d.
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Approximate Interval Between Onset and Death

IF FEMALE

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☒ No
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 5 ☐ Other (specify)
9 ☐ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☒ Yes 2 ☐ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

Jan. 15, 2004

28b. Time of Injury

11:30 A M

28c. Injury at Work?

1 ☐ Yes 2 ☒ No

28d. Describe how injury occurred

Dislodged tracheostomy tube

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

nursing home

28f. Location (Street and Number or Rural Route Number, City or Town, State)

22 So. Athol Ave Baltimore, MD

29a. Certifier (Check only one)

1 ☒ Certifying Physician

To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

[Signature]

29c. License number

D46089

29d. Date signed (Month, Day, Year)

January 18, 2004

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Pharmax Higdon 2000 W. Baltimore Street Baltimore, MD

31. Date filed (Month, Day, Year)

JAN 23 2004

32. Registrar's Signature

[Signature]

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State Registrar

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2004 03834

1- For
State
RegistrarPhysician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

ALBERT EDWARD GORSUCH

2. Date of Death

January 16, 2004 7:30 P.M.

3. Time of Death

Funeral
Director

4a. Facility Name (If not institution, give street and number)

Frederick Memorial Hospital

4b. City, Town, or Location of Death

Frederick

4c. County of Death

Frederick

5. Social Security Number

578-30-8925

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

75 Yrs.

If Under 1 Year

Months

If Under 24 Hrs.

Days

Hours

Min.

8. Date of Birth

(Month, Day, Year)
Sept. 7, 1928

9. Birthplace (State or Foreign Country)

Washington, D.C.

Usual Residence of Decedent

10a. State

Maryland

10b. County

Frederick

10c. City, Town or Location

Frederick

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

905C Blue Leaf Court

10f. Zip Code

21701

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Surveyor

16b. Kind of Business/Industry

Electric Company

17. Father's Name (First, Middle, Last)

Albert Fayette Gorsuch

18. Mother's Name (First, Middle, Maiden Surname)

Mamie Penelope Elliott

19a. Informant's Name/Relationship (Type, Print)

Betty J. Gorsuch/Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

905C Blue Leaf Court, Frederick, Maryland 21701

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Cedar Hill Cemetery

Date

January 20, 2004

20c. Location - City or Town, State

Suitland, Maryland

21. Signature of Funeral Service Licensee

Ray J. [Signature]

M00198

22. Name and Address of Facility

Robert A. Pumphrey Funeral Home/ Bethesda-Chey Chase, Inc.
7557 Wisconsin Ave., Bethesda, MD 20814-3501

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. EMPHYSEMA

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

10 YEARS

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☐ No
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy
4 ☐ Pregnant at time of death 5 ☐ Other (specify)
9 ☐ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

METASTATIC COLON CANCER

AORTIC ANEURYSM

PERIPHERAL VASCULAR DISEASE

23e. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury

(Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Mary P. Howell MD

29c. License number

D46075

29d. Date signed (Month, Day, Year)

1/17/04

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Mary P. Howell, M.D. 65C Thomas Johnson Drive, Frederick, Maryland 21702

31. Date filed (Month, Day, Year)

JAN 20 2004

32. Registrar's Signature

[Signature]

State
Registrar

Baltimore, Maryland 21215-0036

perml. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

1- For
State
Registrar

2004 03835

Physician
/Medical
ExaminerFuneral
Director

1. Decedent's Name (First, Middle, Last)

HYMAN

GOLDSTEIN

2. Date of Death

Month Day Year
JANUARY 22, 2004

3. Time of Death

2:10A M

4a. Facility Name (If not institution, give street and number)

COLLINGSWOOD NURSING HOME

4b. City, Town, or Location of Death

ROCKVILLE

4c. County of Death

MONTGOMERY

5. Social Security Number

052-10-2891

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

88 Yrs.

If Under 1 Year

Months

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
10/07/1915

9. Birthplace (State or Foreign Country)

NEW YORK

Usual Residence of Decedent

10a. State

NEW YORK

10b. County

BRONX

10c. City, Town or Location

BRONX

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

4715 OSMAN PLACE

10f. Zip Code

10470

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: WHITE

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working
life. DO NOT use retired)

BUSINESS OWNER

16b. Kind of Business/Industry

HOME IMPROVEMENT

17. Father's Name (First, Middle, Last)

SAMUEL GOLDSTEIN

18. Mother's Name (First, Middle, Maiden Surname)

BESSIE WOLFSON

19a. Informant's Name/Relationship (Type, Print)

STEPHEN B. GOLDSTEIN/SON

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

10 GERARD COURT, ROCKVILLE, MARYLAND 20850

20a. Method of Disposition

1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☒ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

CEDAR PARK CEMETERY

Date

JAN 25, 2004

20c. Location - City or Town, State

PARAMUS, NEW JERSEY

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

EDWARD SAGEL FUNERAL DIRECTION, INC.
1091 ROCKVILLE PIKE, ROCKVILLE, MARYLAND 2085223a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Approximate
Interval Between
Onset and DeathImmediate Cause (Final
disease or condition
resulting in death)

a. ENDSTAGE OBSTRUCTIVE LUNG DISEASE

Due to (or as a consequence of):

b. COR PULMONALE

Due to (or as a consequence of):

c. CHRONIC OBSTRUCTIVE PULMONARY DISEASE

Due to (or as a consequence of):

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

IF FEMALE:

23b. Was decedent pregnant
in the past 12 months?1 ☐ Yes 2 ☐ No
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
5 ☐ Other (Specify)
9 ☐ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

PNEUMONIA

ACUTE MYOCARDIAL INFARCTION

23e. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown24a. Was an
autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings available
prior to completion of cause of
death?1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending
investigation
2 ☐ Accident 6 ☐ Could not be
determined
3 ☐ Suicide 4 ☐ Homicide28a. Date of Injury
(Month, Day Year)28b. Time of
Injury

M

28c. Injury at
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

45839

29d. Date signed (Month, Day, Year)

JANUARY 22, 2004

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DR. GARY RAFFEL, 5411 WEST CEDAR LANE, SUITE 202A, BETHESDA, MARYLAND 20814

31. Date filed (Month, Day, Year)

JAN 23 2004

32. Registrar's Signature

[Signature]

State
Registrar

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2004 03836

1- For
State
RegistrarPhysician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

MORRIS GOLDEN

2. Date of Death

JANUARY 18, 2004

3. Time of Death

7:00A M

4a. Facility Name (If not institution, give street and number)

MANOR CARE

4b. City, Town, or Location of Death

BETHESDA

4c. County of Death

MONTGOMERY

Funeral
Director

5. Social Security Number

577-22-5274

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

90

If Under 1 Year

Months

If Under 24 Hrs.

Days

Hours

Min.

8. Date of Birth

APRIL 4, 1913

9. Birthplace (State or Foreign Country)

MARYLAND

Usual Residence of Decedent

10a. State

MARYLAND

10b. County

MONTGOMERY

10c. City, Town or Location

ROCKVILLE

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

2606 OAKENSHIELD DRIVE

10f. Zip Code

20854

10g. Citizen of What Country?

UNITED STATES OF AMERICA

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

1

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

MERCHANT

16b. Kind of Business/Industry

GROCERY

17. Father's Name (First, Middle, Last)

PHILIP GOLDEN

18. Mother's Name (First, Middle, Maiden Surname)

ROSA SUGARMAN

19a. Informant's Name/Relationship (Type, Print)

LOIS M. GOLDEN - DAUGHTER

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

5040 DANA PLACE, NW WASHINGTON, DC 20016

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

JUDEAN MEMORIAL GARDEN 01/22/04

Date

20c. Location - City or Town, State

OLNEY, MARYLAND

21. Signature of Funeral Service Licensee

Donald C. Stottmeyer

22. Name and Address of Facility

DANZANSKY GOLDBERG MEMORIAL CHAPEL, INC.
1170 ROCKVILLE PIKE, ROCKVILLE, MD 20852

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

RESPIRATORY FAILURE

a. Due to (or as a consequence of):

DYSPHAGIA

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Approximate Interval Between Onset and Death

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☐ No
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy
4 ☐ Pregnant at time of death 5 ☐ Other (specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

DEMENTIA

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

m Vemury

29c. License number

D35791

29d. Date signed (Month, Day, Year)

JANUARY 20, 2004

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MERLYN K. VEMURY, MD., 9801 GEORGIA AVE. SUITE 227, SILVER SPRING, MD 20902

31. Date filed (Month, Day, Year)

JAN 22 2004

32. Registrar's Signature

Sparks

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2004 03837

1- For
State
RegistrarPhysician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

PHILIP M. GLICK

2. Date of Death

Month JANUARY 17, 2004

3. Time of Death

4:00P M

4a. Facility Name (If not institution, give street and number)

116 EAST MELROSE

4b. City, Town, or Location of Death

CHEVY CHASE

4c. County of Death

MONTGOMERY

Funeral
Director

5. Social Security Number

218-34-5256

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

98

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
DEC. 9, 1905

9. Birthplace (State or Foreign Country)

ILLINOIS

Usual Residence of Decedent

10a. State

MARYLAND

10b. County

MONTGOMERY

10c. City, Town or Location

CHEVY CHASE

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

116 EAST MELROSE

10f. Zip Code

20815

10g. Citizen of What Country?

UNITED STATES OF AMERICA

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☒ Yes 2 ☐ No
If Yes, Give Year or Dates UNKNOWN

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4or 5+)

5+

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

ATTORNEY

16b. Kind of Business/Industry

LAW

17. Father's Name (First, Middle, Last)

DAVID GLICK

18. Mother's Name (First, Middle, Maiden Surname)

BRONNA RIVA "UNKNOWN"

19a. Informant's Name/Relationship (Type, Print)

STEVEN A. WIDDES - GUARDIAN

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
c/o PALEY ROTHMAN 4800 HAMPDEN LANE SUITE 700
BETHESDA, MARYLAND 20814

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

MENORAH GARDENS

Date

01/21/04

20c. Location - City or Town, State

ROCKVILLE, MARYLAND

21. Signature of Funeral Service Licensee

22. Name and Address of Facility
DANZANSKY GOLDBERG MEMORIAL CHAPEL, INC.
1170 ROCKVILLE PIKE, ROCKVILLE, MD 20852

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. ALZHEIMER'S DEMENTIA

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death
YEARS

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy
4 ☐ Pregnant at time of death 5 ☐ Other (specify)
9 ☐ Unknown23d. Date of delivery
Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy performed?
1 ☐ Yes 2 ☒ No24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No25. Was case referred to medical examiner?
1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA26. Place of Death (Check only one)
Other: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Martin C. Shargel

29c. License number

D08944

29d. Date signed (Month, Day, Year)

JANUARY 20, 2004

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MARTIN C. SHARGEL, M.D., 3720 FARRAGUT AVENUE, KENSINGTON, MD 20895

State
Registrar

31. Date filed (Month, Day, Year)

JAN 22 2004

32. Registrar's Signature

B. Spauld

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2004 03838

1- For
State
RegistrarPhysician
/Medical
ExaminerFuneral
Director

1. Decedent's Name (First, Middle, Last)

Bessie Marie Givens

2. Date of Death

Month

Day

Year

January

30

2004

3. Time of Death

1135 A^M

4a. Facility Name (If not institution, give street and number)

Union Hospital

4b. City, Town, or Location of Death

Elkton

4c. County of Death

Cecil

5. Social Security Number

216-30-8110

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

85

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

FEB 18, 1918

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Cecil

10c. City, Town or Location

Elkton

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

216 East High Street

10f. Zip Code

21921

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify:

Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

11

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Dietary Aide

16b. Kind of Business/Industry

Veterans Administration

17. Father's Name (First, Middle, Last)

William D. Wilson

18. Mother's Name (First, Middle, Maiden Surname)

Lucy Anderson

19a. Informant's Name/Relationship (Type, Print)

Oliver G. Givens, Sr./Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

9 Chestnut Drive, Elkton, Maryland 21921

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Bohemia Manor Cemetery

Date

February 5, 2004

20c. Location - City or Town, State

Chesapeake City, Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Hicks Home for Funerals, P.A.

1103 W. Stockton Street, Elkton, Maryland 21921

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Corda one st

Due to (or as a consequence of):

b. Heart failure

Due to (or as a consequence of):

c. Heart attack

Due to (or as a consequence of):

d. CAD

Approximate Interval Between Onset and Death

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☒ No3 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death5 ☐ Other (specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Colitis
Diabetes Mellitus

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☒ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D0060756

29d. Date signed (Month, Day, Year)

1/30/04

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Ozden Coksaygon MD 223 W Main Street, Elkton

31. Date filed (Month, Day, Year)

FEB 10 2004

32. Registrar's Signature

State
Registrar

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2004 03839

1- For Unpend Item #23a, pt. II, 27 per me G828 Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

LAWRENCE WARDALL GINN

2. Date of Death

February 01, 2004

3. Time of Death

2015 P M

Funeral
Director

4a. Facility Name (If not institution, give street and number)

207 Laurel Street Apartment C

4b. City, Town, or Location of Death

Pocomoke

4c. County of Death

Worcester

5. Social Security Number

327-34-4461

6. Sex

M 2 F

7. Age (In yrs. last birthday)

62 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

June 5, 1941

9. Birthplace (State or Foreign Country)

MD

Usual Residence of Decedent

10a. State

MD

10b. County

WORCESTER

10c. City, Town or Location

Pocomoke

10d. Inside City Limits

1 Yes 2 No

10e. Street and Number

207 Laurel ST Apt. C

10f. Zip Code

21851

10g. Citizen of What Country?

U.S.A

11. Marital Status

1 Never Married 2 Married
3 Widowed 4 Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 Yes 2 No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

LABORER

16b. Kind of Business/Industry

Poultry Industry

17. Father's Name (First, Middle, Last)

LUTHER M. IBOURNE

18. Mother's Name (First, Middle, Maiden Surname)

BERNICE HOLLAND

19a. Informant's Name/Relationship (Type, Print)

BERNICE G. HOLLAND - Mother

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

809 2nd St. Pocomoke, MD 21851

20a. Method of Disposition

1 Burial 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Johns Neck Cemetery

Date

2-7-4

20c. Location - City or Town, State

Pocomoke, MD

21. Signature of Funeral Service Licensee

Anthony E. Ward Sr.

22. Name and Address of Facility

Anthony E. Ward Funeral Home
30634 Hampden Ave. Princess Anne, MD 21853

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Arteriosclerotic cardiovascular disease

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):

Due to (or as a consequence of):

Due to (or as a consequence of):

Due to (or as a consequence of):

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?
1 Yes 2 No
9 Unknown

23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death 3 Ectopic pregnancy
4 Pregnant at time of death 5 Other (specify)
9 Unknown23d. Date of delivery
Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Diabetes mellitus

23e. Did tobacco use contribute to the cause of death?

1 Yes 2 No 3 Probably 4 Unknown

24a. Was an autopsy performed?
1 Yes 2 No24b. Were autopsy findings available prior to completion of cause of death?
1 Yes 2 No

25. Was case referred to medical examiner?

1 Yes 2 No

Hospital:

1 Inpatient 2 ER/Outpatient 3 DOA

Other:

4 Nursing Home 5 Residence 6 Other (Specify) At scene

27. Manner of Death

1 Natural 2 Accident 3 Suicide 4 Homicide
5 Pending investigation 6 Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 Yes 2 No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

J. L. Aiken

29c. License number

O.C.M.E.

29d. Date signed (Month, Day, Year)

February 02, 2004

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

J. L. Aiken, MD

111 Penn Street, Baltimore, Maryland 21201

State
Registrar

31. Date filed (Month, Day, Year)

FEB 06 2004

32. Registrar's Signature

Heaven & Spence

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2004 03840

1- For
State
RegistrarPhysician
/Medical
ExaminerFuneral
Director

1. Decedent's Name (First, Middle, Last)

Martha E. Greene

2. Date of Death

January 18 2004

3. Time of Death

8:00 A^M

4a. Facility Name (If not institution, give street and number)

Manor Care Health Services

4b. City, Town, or Location of Death

Silver Spring

4c. County of Death

Montgomery

5. Social Security Number

577-30-0753

6. Sex

1 ☐ M 2 ☒ F

7. Age (in yrs. last birthday)

87 Yrs.

If Under 1 Year

Months

If Under 24 Hrs.

Days

Hours

Min.

8. Date of Birth

Aug. 19, 1916

9. Birthplace (State or Foreign Country)

Virginia

Usual Residence of Decedent

10a. State

Maryland

10b. County

Prince George's

10c. City, Town or Location

Glenn Dale

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

11408 Prospect Court

10f. Zip Code

20769

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: American

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

2

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

Analyst

16b. Kind of Business/Industry

NSA - Government

17. Father's Name (First, Middle, Last)

Charlie Bowman

18. Mother's Name (First, Middle, Maiden Surname)

Mattie Jackson

19a. Informant's Name/Relationship (Type, Print)

Janet Braxton - Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

11408 Prospect Court, Glenn Dale, MD 20769

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Lincoln Memorial Cem.

Date

1/23/2004

20c. Location - City or Town, State

Suitland, MD

21. Signature of Funeral Service Licensee

John T. Stewart III

22. Name and Address of Facility

Stewart Funeral Home

4001 Benning Rd., N.E. Wash., DC 20019

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,

shock, or heart failure. List only one cause on each line.

Immediate Cause (Final

disease or condition

resulting in death)

a. pneumonia

Due to (or as a consequence of):

Sequentially list conditions,

if any, leading to immediate

cause. Enter Underlying

Cause (Disease or injury

that initiated events

resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate

Interval Between

Onset and Death

Weeks

IF FEMALE:

23b. Was decedent pregnant

in the past 12 months?

1 ☐ Yes 2 ☐ No9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death4 ☐ Pregnant at time of death9 ☐ Unknown3 ☐ Ectopic pregnancy5 ☐ Other (specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

25. Was case referred to medical

examiner?

1 ☐ Yes 2 ☒ No

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending

Investigation

6 ☐ Could not be

determined

Hospital: 1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☒ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

28a. Date of Injury

(Month, Day Year)

28b. Time of

Injury

M

28c. Injury at

Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office

building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number,

City or Town, State)

29a. Certifier

(Check only

one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

and manner stated.

29b. Signature and title of certifier

Lalitha Tadikonda, M.D.

29c. License number

D56797

29d. Date signed (Month, Day, Year)

January 20, 2004

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

13952 BALTIMORE AVENUE, LAUREL, MD 20707

31. Date filed (Month, Day, Year)

JAN 22 2004

32. Registrar's Signature

Heidi K. Smith

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.Physician
/Medical
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2004 03841

1- For
State
RegistrarPhysician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

EMILY BORTON GARNER

2. Date of Death

Month Day Year
JANUARY 13, 2004

3. Time of Death

11:50P M

Funeral
Director

4a. Facility Name (If not institution, give street and number)

MARINER HEALTH OF GREATER LAUREL

4b. City, Town, or Location of Death

LAUREL

4c. County of Death

PRINCE GEORGES

5. Social Security Number

220 34 2759

6. Sex

1 ☐ M ☒ F

7. Age (In yrs. last birthday)

88 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
NOV. 10, 1915

9. Birthplace (State or Foreign Country)

NEW JERSEY

Usual Residence of Decedent

10a. State

MARYLAND

10b. County

PRINCE GEORGES

10c. City, Town or Location

CAPITOL HEIGHTS

10d. Inside City Limits

☒ Yes ☐ No

10e. Street and Number

204 SHADY GLEN DRIVE

10f. Zip Code

20743

10g. Citizen of What Country?

UNITED STATES

11. Marital Status

1 ☐ Never Married 2 ☐ Married☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes ☒ No

If Yes, Give

Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: WHITE

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

4TH

College (1-4 or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working

life. DO NOT use retired)

HOMEMAKER

16b. Kind of Business/Industry

17. Father's Name (First, Middle, Last)

BENJAMIN L. CAMP

18. Mother's Name (First, Middle, Maiden Surname)

ANNA ADAMS

19a. Informant's Name/Relationship (Type, Print)

ELIZA DONOVAN / DAUGHTER

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

454 AUDREYS LANE LOUISA, VA 23093

20a. Method of Disposition

1 ☐ Burial ☒ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

METROPOLITAN CREMATORY 01/15/04

Date

20c. Location - City or Town, State

ALEXANDRIA, VA

21. Signature of Funeral Service Licensee

J. Marshall

22. Name and Address of Facility

MARSHALL'S FUNERAL HOME OF MARYLAND, INC.

4308 SUITLAND ROAD SUITLAND, MD 20746

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. HYPERTENSIVE CARDIOVASCULAR DISEASE

Due to (or as a consequence of):

Approximate Interval Between Onset and Death
MANY YEARS

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☐ No
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death4 ☐ Pregnant at time of death9 ☐ Unknown3 ☐ Ectopic pregnancy5 ☐ Other (Specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

DEMENTIA

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOAOther: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation
2 ☐ Accident 6 ☐ Could not be determined
3 ☐ Suicide
4 ☐ Homicide

28a. Date of Injury

(Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier
(Check only one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

A. Bortin MD

29c. License number

D23181

29d. Date signed (Month, Day, Year)

1-15-2004

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

R-G. BHOTRAJ MD, 704 GORMAN AVE # T-1, LAUREL, MD 20707

31. Date filed (Month, Day, Year)

JAN 21 2004

32. Registrar's Signature

[Signature]

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

1- For State Registrar

2004 03842

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Eva E. Gantt				2. Date of Death Month Day Year January 20, 2004				3. Time of Death 12:25A M			
	4a. Facility Name (If not institution, give street and number) Southern Maryland Hospital				4b. City, Town, or Location of Death Clinton				4c. County of Death Prince George			
Funeral Director	5. Social Security Number 411-48-3728		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 91 Yrs.		8. Date of Birth (Month, Day, Year) Sept. 20, 1912		9. Birthplace (State or Foreign Country) Tennessee			
	Usual Residence of Decedent											
To Be Completed by Funeral Director	10a. State Maryland		10b. County Prince George		10c. City, Town or Location Forestville				10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No			
	10e. Street and Number 7420 Marlboro Pike				10f. Zip Code 20747				10g. Citizen of What Country? United States			
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: Black			
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker				16b. Kind of Business/Industry Private			
	17. Father's Name (First, Middle, Last) Samuel Pierce				18. Mother's Name (First, Middle, Maiden Surname) Rachel Dykes							
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) Anna Coley/Daughter				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2416 W. Hampton Rd., Avon Park, Florida 33825							
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Washington National				Date Jan. 26, 2004		20c. Location - City or Town, State Suitland, MD.	
	21. Signature of Funeral Service Licensee Ava Mikell				22. Name and Address of Facility Pope Funeral Homes 5538 Marlboro Pike Forestville, MD. 20747							
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. a. SEPTICEMIA Due to (or as a consequence of): b. GANGRENE Due to (or as a consequence of): c. PERIPHERAL VASCULAR DISEASE Due to (or as a consequence of): d.											
	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 9 <input type="checkbox"/> Unknown				23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) 9 <input type="checkbox"/> Unknown				23d. Date of delivery Month Day Year			
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.												
23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown												
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No												
24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No												
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No												
26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)												
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined												
28a. Date of Injury (Month, Day Year)				28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred				
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)								28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.												
29b. Signature and title of certifier Sherif Hassan, MD				29c. License number D50862				29d. Date signed (Month, Day, Year) JANUARY, 20, 2004				
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Sherif Hassan, MD 9831 Greenbelt Rd. #103 Lanham, MD 20706												
31. Date filed (Month, Day, Year) JAN 21 2004				32. Registrar's Signature [Signature]								

Baltimore, Maryland 21215-0036
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2004 03843

1- For
State
RegistrarPhysician
/Medical
ExaminerFuneral
Director

1. Decedent's Name (First, Middle, Last)

Maria Cecilia Mata-De Gaitan

2. Date of Death

Month

Day

Year

01

20

04

3. Time of Death

1019A M

4a. Facility Name (If not institution, give street and number)

Washington Adventist Hospital

4b. City, Town, or Location of Death

Takoma Park

4c. County of Death

Montgomery

5. Social Security Number

N/A

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

73

Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

(Month, Day, Year)

Nov 22, 1930

9. Birthplace (State or Foreign Country)

El Salvador

Usual Residence of Decedent

10a. State

Maryland

10b. County

Prince George's

10c. City, Town or Location

Hyattsville

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

8125 14th Avenue

10f. Zip Code

20783

10g. Citizen of What Country?

El Salvador

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

2 ☒ Yes 2 ☐ No Specify: El Salvadorian

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary (0-12)

0

College (1-4or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Private

17. Father's Name (First, Middle, Last)

Arcadio Melara Martinez

18. Mother's Name (First, Middle, Maiden Sumame)

Maria Leandra Mata

19a. Informant's Name/Relationship (Type, Print)

Jose Gaitan-Mata (Son)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

8125 14th Avenue, Hyattsville, MD 20783

20a. Method of Disposition

1 ☐ Burial 2 ☐ Cremation 3 ☒ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Cementerio General

Date

1/30/2004

20c. Location - City or Town, State

Jaquillisco, El Salvador

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Rendon/Hale Funeral Home

9013 Annapolis Road, Lanham MD 20706

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Hypotension
Due to (or as a consequence of):b. Sepsis
Due to (or as a consequence of):c. Bilateral lower lobe infiltrates
Due to (or as a consequence of):

d.

Approximate Interval Between Onset and Death

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☒ No9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death4 ☐ Pregnant at time of death 5 ☐ Other (specify)9 ☐ Unknown

23d. Date of delivery

Month

Day

Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Disseminated Intravascular Coagulation
Atrial fibrillation and heart failure
Metabolic acidosis
acute renal failure

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number

60953

29d. Date signed (Month, Day, Year)

1/20/04

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1300 Piccard Drive #202

Deanna R MD White

31. Date filed (Month, Day, Year)

JAN 22 2004

32. Registrar's Signature

State Registrar

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23e or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
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Important: If item 27 is marked other than "natural", or items 23e or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2004 03844

Certificate of Death

Reg. No.

1- For
State
RegistrarPhysician
/Medical
ExaminerFuneral
Director

1. Decedent's Name (First, Middle, Last)

Dorothea Anne Hrindac

2. Date of Death

Month Day Year
January 20, 2004

3. Time of Death

6:05 A M

4a. Facility Name (If not institution, give street and number)

Holy Cross Hospital

4b. City, Town, or Location of Death

Silver Spring

4c. County of Death

Montgomery

5. Social Security Number

156-22-3130

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

73

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
September 4, 1930

9. Birthplace (State or Foreign Country)

New Jersey

Usual Residence of Decedent

10a. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Bethesda

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

8005 Park Lane

10f. Zip Code

20814

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: White

15. Decedent's Education
(Specify only highest grade completed)Elementary/Secondary (0-12)
12

College (1-4or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

James Frawley

18. Mother's Name (First, Middle, Maiden Surname)

Charlotte Scott

19a. Informant's Name/Relationship (Type, Print)

William G. Hrindac /Husband

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

8005 Park Lane, Bethesda, Maryland 20814

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Gate of Heaven Cemetery

Date

January 24,
2004

20c. Location - City or Town, State

Silver Spring, Maryland

21. Signature of Funeral Service Licensee

M01305

22. Name and Address of Facility

Robert A. Pumphrey Funeral Home/Bethesda-Chevy Chase, Inc.
7557 Wisconsin Avenue, Bethesda, Maryland 20814-350123a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

a. Congestive Heart Failure

Due to (or as a consequence of):

b. Chronic Renal Failure

Due to (or as a consequence of):

c. Pneumonia

Due to (or as a consequence of):

d. Chronic Obstructive Pulmonary Disease

Approximate
Interval Between
Onset and Death

IF FEMALE:

23b. Was decedent pregnant
in the past 12 months?1 ☐ Yes 2 ☒ No
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 5 ☐ Other (specify)
9 ☐ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☒ Probably 4 ☐ Unknown24a. Was an
autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings available
prior to completion of cause of
death?1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending
investigation
2 ☐ Accident 6 ☐ Could not be
determined
3 ☐ Suicide 4 ☐ Homicide28a. Date of Injury
(Month, Day Year)28b. Time of
Injury28c. Injury at
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
and manner stated.

29b. Signature and title of certifier

29c. License number

D00058968

29d. Date signed (Month, Day, Year)

January 20, 2004

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Saima Khawaja, M.D 11119 Rockville Pike, Rockville, Maryland 20852

31. Date filed (Month, Day, Year)

JAN 22 2004

32. Registrar's Signature

State
Registrar

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show
any injury or other traumatic event, the Medical Examiner must be notified at
once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

1- For
State
Registrar

2004 03845

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Physician
/Medical
ExaminerFuneral
Director

1. Decedent's Name (First, Middle, Last) Christine P. Howard				2. Date of Death Month Day Year January 16, 2004		3. Time of Death 12:45A M	
4a. Facility Name (If not institution, give street and number) Rockville Nursing Home				4b. City, Town, or Location of Death Rockville		4c. County of Death Montgomery	
5. Social Security Number 579-28-8934		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 89 Yrs.		8. Date of Birth (Month, Day, Year) Dec. 25, 1914	
9. Birthplace (State or Foreign Country) Maryland		10a. State Maryland		10b. County Montgomery		10c. City, Town or Location Gaithersburg	
10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		10e. Street and Number 1010 Quince Orchard Road		10f. Zip Code 20878		10g. Citizen of What Country? United States	
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) -		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Laboratory Technician		16b. Kind of Business/Industry National Institutes of Health		17. Father's Name (First, Middle, Last) Sidney S. Connell	
18. Mother's Name (First, Middle, Maiden Surname) Hattie Violet		19a. Informant's Name/Relationship (Type, Print) Ronald L. Federline/ Son		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2998 Summit Drive, Ijamsville, Maryland 21754		20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)	
20b. Place of Disposition (Name of cemetery, crematory or other place) Darnestown Presbyterian Church Cemetery		20c. Date January 20, 2004		20d. Location - City or Town, State Darnestown, Maryland		21. Signature of Funeral Service Licensee M00689	
22. Name and Address of Facility Robert A. Pumphrey Funeral Home/ Rockville, Inc. 300 West Montgomery Avenue, Rockville, Maryland 20850-2805		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Bilateral Pneumonia Due to (or as a consequence of): Gastrointestinal Bleeding Due to (or as a consequence of): Respiratory Failure Due to (or as a consequence of):		Approximate Interval Between Onset and Death		23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 9 <input type="checkbox"/> Unknown	
23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 4 <input type="checkbox"/> Pregnant at time of death 9 <input type="checkbox"/> Unknown		3 <input type="checkbox"/> Ectopic pregnancy 5 <input type="checkbox"/> Other (specify)		23d. Date of delivery Month Day Year		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)	
28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	
28f. Location (Street and Number or Rural Route Number, City or Town, State)		29a. Certifier (Check only one) 2 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier Thomas V. Joseph		29c. License number D47330	
29d. Date signed (Month, Day, Year) January 19, 2004		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Thomas V. Joseph, M.D. 50 West Edmonston Drive, # 207, Rockville, Maryland 20852		31. Date filed (Month, Day, Year) JAN 20 2004		32. Registrar's Signature James B. Sparks	

State
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar AMEND#12 per INF1/28/04, BW, MCO

Certificate of Death

Reg. No. 2004 03846

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Physician /Medical Examiner

Funeral Director

To Be Completed by Funeral Director

Medical Certification; To Be Completed by Physician/Medical Examiner

1. Decedent's Name (First, Middle, Last) Dennis G. Hovis		2. Date of Death Month JANUARY Day 15 Year 2004		3. Time of Death 5:27 PM	
4a. Facility Name (If not institution, give street and number) Union Memorial Hospital		4b. City, Town, or Location of Death Baltimore		4c. County of Death	
5. Social Security Number 579-56-5139		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 56 Yrs.	
8. Date of Birth (Month, Day, Year) Aug. 5, 1947		9. Birthplace (State or Foreign Country) Wash. D.C.			
10a. State Maryland		10b. County Baltimore		10c. City, Town or Location Baltimore	
10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		10e. Street and Number 340 E. 28th Street		10f. Zip Code 21218	
10g. Citizen of What Country? United States		11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: 8-14-68 8-11-72	
13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) College	
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Carpenter		16b. Kind of Business/Industry Construction		17. Father's Name (First, Middle, Last) Lester Hovis	
18. Mother's Name (First, Middle, Maiden Surname) Gloria Chow		19a. Informant's Name/Relationship (Type, Print) Amy Hovis (daughter)		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) P.O. Box 9, Geigertown, PA 19523	
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Chesapeake Crematory		20c. Location - City or Town, State 1/23/04 Beltsville, Maryland	
21. Signature of Funeral Service Licensee Richard Thompson		22. Name and Address of Facility McGuire Funeral Service 7400 Georgia Ave. N.W., Washington, D.C. 20012			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. ISCHEMIC CARDIOMYOPATHY HYPERTENSION UNSTABLE					
23b. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.					
23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <input type="checkbox"/> Unknown					
23d. Date of delivery Month Day Year					
23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown					
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined					
28a. Date of Injury (Month, Day Year)					
28b. Time of Injury M <input type="checkbox"/> Yes <input type="checkbox"/> No					
28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No					
28d. Describe how injury occurred					
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)					
28f. Location (Street and Number or Rural Route Number, City or Town, State)					
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.					
29b. Signature and title of certifier R. Ayash M.D.					
29c. License number D0020111					
29d. Date signed (Month, Day, Year) JANUARY 15, 2004					
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) RITA AYASH UNION MEMORIAL HOSPITAL 301 E. UNIVERSITY BLVD					
31. Date filed (Month, Day, Year) JAN 22 2004					
32. Registrar's Signature [Signature]					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2004 03847

1- For
State
Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Regina M. Holten			2. Date of Death Month Day Year January 17 2004		3. Time of Death 5:35 PM	
	4a. Facility Name (If not institution, give street and number) Shady Grove Adventist Hospital			4b. City, Town, or Location of Death Rockville		4c. County of Death Montgomery	
Funeral Director	5. Social Security Number 483-32-6024		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 69 Yrs.		8. Date of Birth (Month, Day, Year) Apr. 1, 1934
	9. Birthplace (State or Foreign Country) Iowa		10a. State Maryland		10b. County Montgomery		10c. City, Town or Location Rockville
To Be Completed by Funeral Director	10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		10e. Street and Number 14202 Castaway Drive		10f. Zip Code 20853		10g. Citizen of What Country? United States
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White
To Be Completed by Physician/Medical Examiner	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 4		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Teacher		16b. Kind of Business/Industry Education		
	17. Father's Name (First, Middle, Last) Edward Mason		18. Mother's Name (First, Middle, Maiden Surname) Lyaall O'Connor				
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) John W. Holten / Husband		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 14202 Castaway Drive Rockville, Maryland 20853				
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Gate of Heaven Cem.		Date Jan. 22, 2004		20c. Location - City or Town, State Silver Spring, MD
To Be Completed by Physician/Medical Examiner	21. Signature of Funeral Service Licensee 		22. Name and Address of Facility DeVol Funeral Home 10 E. Deer Park Dr. Gaithersburg, MD 20877				
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Bilateral Pneumonia Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last		Approximate Interval Between Onset and Death 11 Days				
To Be Completed by Physician/Medical Examiner	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 9 <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 4 <input type="checkbox"/> Pregnant at time of death 9 <input type="checkbox"/> Unknown		3 <input type="checkbox"/> Ectopic pregnancy 5 <input type="checkbox"/> Other (specify)		23d. Date of delivery Month Day Year
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown				
To Be Completed by Physician/Medical Examiner	24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No				
	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)				
To Be Completed by Physician/Medical Examiner	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
	28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)		
To Be Completed by Physician/Medical Examiner	29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier 				
	29c. License number D58681		29d. Date signed (Month, Day, Year) January 18, 2004				
To Be Completed by Physician/Medical Examiner	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Jude Alexander, M.D. 9901 Medical Center Dr. Rockville, Maryland 20850		31. Date filed (Month, Day, Year) JAN 20 2004				
	32. Registrar's Signature 		33. State Registrar JAN 20 2004				

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2004 03848

1- For
State
Registrar

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Antonio Casado Hernandez

2. Date of Death

Jan. 21, 2004

3. Time of Death

4:14p M

Funeral
Director

4a. Facility Name (If not institution, give street and number)

Casey House

4b. City, Town, or Location of Death

Rockville

4c. County of Death

Montgomery

5. Social Security Number

580-14-0803

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

60 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

July 1, 1943

9. Birthplace (State or Foreign Country)

Spain

Usual Residence of Decedent

10a. State

MD

10b. County

Montgomery

10c. City, Town or Location

Silver Spring

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

1808 Sanford Road

10f. Zip Code

20902

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☒ Yes 2 ☐ No Specify: Spain14. Race - American Indian,
Black, White, etc.

Specify: White

15. Decedent's Education
(Specify only highest grade completed)Elementary/Secondary (0-12)
12

College (1-4 or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Butler

16b. Kind of Business/Industry

Embassy of Spain

17. Father's Name (First, Middle, Last)

Manuel Casado San Gregorio

18. Mother's Name (First, Middle, Maiden Surname)

Consuelo Hernandez Mendez

19a. Informant's Name/Relationship (Type, Print)

Maria Del Pilar Casado/Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1808 Sanford Road Silver Spring, Md 20902

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Chesapeake Crem. 1/24/04

Date

20c. Location - City or Town, State

Beltsville, Md

21. Signature of Funeral Service Licensee

Philip D. Rinaldi

22. Name and Address of Facility

PHILIP D. RINALDI FUNERAL SERVICE, P.A.
9241 Columbia Blvd. Silver Spring, Md 2091023a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

a. Hepatocellular carcinoma

Due to (or as a consequence of):

Approximate
Interval Between
Onset and Death

weeks

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

IF FEMALE:

23b. Was decedent pregnant

in the past 12 months?
1 ☐ Yes 2 ☐ No
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy
4 ☐ Pregnant at time of death 5 ☐ Other (specify)
9 ☐ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an
autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings available
prior to completion of cause of
death?1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☒ Other (Specify) hospice

27. Manner of Death

1 ☒ Natural 5 ☐ Pending
investigation
2 ☐ Accident 6 ☐ Could not be
determined
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury

(Month, Day, Year)

28b. Time of
injury

M

28c. Injury at
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Philip D. Rinaldi

29c. License number

D42452

29d. Date signed (Month, Day, Year)

1/21/2004

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Chitra Rajagopal MD 18111 Prince Phillip Dr. Olney, Md 20835

State
Registrar

31. Date filed (Month, Day, Year)

JAN 23 2004

32. Registrar's Signature

B. Sparks

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show
any injury or other traumatic event, the Medical Examiner must be notified at
once.To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit
certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene
Certificate of Death

2004 03849

1- For
State
Registrar

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) GEORGE HEILBORN				2. Date of Death Month JAN Day 08 Year 2004		3. Time of Death 7:45 P ^M	
	4a. Facility Name (If not institution, give street and number) NATIONAL NAVAL MEDICAL CENTER				4b. City, Town, or Location of Death BETHESDA		4c. County of Death MONTGOMERY	
Funeral Director	5. Social Security Number 102-20-3960		6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		7. Age (In yrs. last birthday) 78 Yrs.		8. Date of Birth (Month, Day, Year) 01/31/1925	
	9. Birthplace (State or Foreign Country) GERMANY		10. Usual Residence of Decedent 10a. State VIRGINIA 10b. County FAIRFAX 10c. City, Town or Location VIENNA 10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates: 1949-85	
To Be Completed by Funeral Director	13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: WHITE		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 5+ College (1-4 or 5+) 5+ 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) GEOLOGIST		16b. Kind of Business/Industry FEDERAL GOVERNMENT	
	17. Father's Name (First, Middle, Last) HERMAN HEILBORN		18. Mother's Name (First, Middle, Maiden Surname) JULIE ZAMORI		19a. Informant's Name/Relationship (Type, Print) LILLIAN HEILBORN/WIFE		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8722 OLD COURTHOUSE RD., VIENNA, VIRGINIA 22182	
To Be Completed by Physician/Medical Examiner	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) QUANTICO NAT'L CEM.		20c. Location - City or Town, State QUANTICO, VIRGINIA		21. Signature of Funeral Service Licensee 	
	22. Name and Address of Facility DANZANSKY-GOLDBERG MEMORIAL CHAPELS, INC. 1170 ROCKVILLE PIKE, ROCKVILLE, MD 20852		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. LUNG CANCER Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of):		23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify)	
To Be Completed by Physician/Medical Examiner	23d. Date of delivery Month Day Year		23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown		24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year) 28b. Time of Injury M 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 28d. Describe how injury occurred 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)	
State Registrar	29a. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier 		29c. License number 01055104A (IN)		29d. Date signed (Month, Day, Year) Jan, 09, 2004	
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MICHAEL R. BAYDARIAN LT MC USNR NATIONAL NAVAL MEDICAL CENTER BETHESDA MD 20889-5600		31. Date filed (Month, Day, Year) JAN 20 2004		32. Registrar's Signature 			

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, a Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2004 03850

1- For
State
Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Kathleen Goldie Brown Hardman				2. Date of Death Month Day Year January 18, 2004		3. Time of Death 2:11 A M	
	4a. Facility Name (If not institution, give street and number) Montgomery General Hospital				4b. City, Town, or Location of Death Olney		4c. County of Death Montgomery	
Funeral Director	5. Social Security Number 578-54-8372		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 88 Yrs.		8. Date of Birth (Month, Day, Year) June 17, 1915	
	9. Birthplace (State or Foreign Country) Newark, NJ		10a. State Maryland		10b. County Sandy Spring		10c. City, Town or Location Sandy Spring	
To Be Completed by Funeral Director	10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		10e. Street and Number 17310 Quaker Lane C 10		10f. Zip Code 20860		10g. Citizen of What Country? United States	
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: African American	
To Be Completed by Physician/Medical Examiner	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 5+		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Registered Nurse		16b. Kind of Business/Industry Medical		17. Father's Name (First, Middle, Last) Henry J. Brown	
	18. Mother's Name (First, Middle, Maiden Surname) Kathleen Goldie Burner		19a. Informant's Name/Relationship (Type, Person) Stepdaughter Youtha C. Hardman-Cromwell		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2015 13th St. N.W., Washington, D.C. 20009-4434		20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input checked="" type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)	
To Be Completed by Physician/Medical Examiner	20b. Place of Disposition (Name of cemetery, crematory or other place) Evergreen Cemetery		20c. Date 1/26/04		20d. Location - City or Town, State Hillside, New Jersey		21. Signature of Funeral Service Licensee Thomas S. Chyburn	
	22. Name and Address of Facility McGuire Funeral Service 7400 Georgia Ave. N.W., Wash. D.C. 20012		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. MYOCARDIAL INFARCTION Due to (or as a consequence of): b. LOWER EXTREMITY ISCHEMIA Due to (or as a consequence of): c. DIABETES MELLITUS Due to (or as a consequence of): d.		Approximate Interval Between Onset and Death 12 days		23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Unknown	
To Be Completed by Physician/Medical Examiner	23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) 9 <input type="checkbox"/> Unknown		23d. Date of delivery Month Day Year		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown	
	24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)	
To Be Completed by Physician/Medical Examiner	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
	28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)		29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.	
To Be Completed by Physician/Medical Examiner	29b. Signature and title of certifier Bruno Schremmer		29c. License number D0060964		29d. Date signed (Month, Day, Year) 01/18/04		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BRUNO SCHREMMER MD 4301 ROSEDALE AVE BETHESDA, MD 20814	
	31. Date filed (Month, Day, Year) JAN 22 2004		32. Registrar's Signature [Signature]		State Registrar		DHMH 17 Rev 1/2001	

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2004 03851

1- For
State
Registrar

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

LIAM HAIM

2. Date of Death

JANUARY 10, 2004

3. Time of Death

4:35 P^MFuneral
Director

4a. Facility Name (If not institution, give street and number)

HOLY CROSS HOSPITAL

4b. City, Town, or Location of Death

SILVER SPRING

4c. County of Death

MONTGOMERY

5. Social Security Number

110-24-5887

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

73 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

04/30/1930

9. Birthplace (State or Foreign Country)

NEW YORK

Usual Residence of Decedent

10a. State

MARYLAND

10b. County

MONTGOMERY

10c. City, Town or Location

SILVER SPRING

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

104 ELDRID DRIVE

10f. Zip Code

20904

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☒ Yes 2 ☐ No
If Yes, Give
Year or Dates: 1956-5813. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: WHITE

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

5+

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

OBYGYN

16b. Kind of Business/Industry

MEDICAL

17. Father's Name (First, Middle, Last)

IRVING

HAIM

18. Mother's Name (First, Middle, Maiden Surname)

MILDRED

SANGER

19a. Informant's Name/Relationship (Type, Print)

GEOFFREY HAIM/SON

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

314 BELFAIR RD., IRMO, SC 29063

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

NATIONAL CREMATORY

Date

01/14/2004

20c. Location - City or Town, State

FALLS CHURCH, VIRGINIA

21. Signature of Funeral Service Licensee

Donald C. Stottumyer

22. Name and Address of Facility

EDWARD SAGEL FUNERAL DIRECTION, INC.
1091 ROCKVILLE PIKE, ROCKVILLE, MD 2085223a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

a. CORONARY ARTERY DISEASE

Due to (or as a consequence of):

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

Approximate
Interval Between
Onset and Death
YEARS

IF FEMALE:

23b. Was decedent pregnant
in the past 12 months?1 ☐ Yes 2 ☒ No
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy
4 ☐ Pregnant at time of death 5 ☐ Other (specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

CHRONIC OBSTRUCTIVE PULMONARY DISEASE

ACUTE BRONCHITIS

DIABETES MELLITUS

23e. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown24a. Was an
autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings available
prior to completion of cause of
death?1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending
investigation
2 ☐ Accident 6 ☐ Could not be
determined
3 ☐ Suicide 4 ☐ Homicide28a. Date of Injury
(Month, Day, Year)28b. Time of
Injury28c. Injury at
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
and manner stated.

29b. Signature and title of certifier

Frank Gravino, M.D.

29c. License number

D0025080

29d. Date signed (Month, Day, Year)

JANUARY 10, 2004

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

FRANK GRAVINO, M.D., 10313 GEORGIA AVENUE, SILVER SPRING, MARYLAND 20902

31. Date filed (Month, Day, Year)

JAN 20 2004

32. Registrar's Signature

Geneva S. Sparks

State
Registrar

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show
any injury or other traumatic event, the Medical Examiner must be notified at
202-343-2000.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2004 03852

1- For State Registrar

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Physician /Medical Examiner

Funeral Director

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

1. Decedent's Name (First, Middle, Last) Gertrude Haflich		2. Date of Death Month January Day 16 Year 2004		3. Time of Death 6:54P M	
4a. Facility Name (If not institution, give street and number) Montgomery General Hospital		4b. City, Town, or Location of Death Olney		4c. County of Death Montgomery	
5. Social Security Number 024-05-6462		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 85 Yrs.	
8. Date of Birth (Month, Day, Year) November 29, 1918		9. Birthplace (State or Foreign Country) Massachusetts			
Usual Residence of Decedent					
10a. State Maryland		10b. County Montgomery		10c. City, Town or Location Silver Spring	
10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
10e. Street and Number 3310 North Leisure World Blvd. #912		10f. Zip Code 20906		10g. Citizen of What Country? U.S.A.	
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:	
14. Race - American Indian, Black, White, etc. Specify: White		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) Bookkeeper			
16. Kind of Business/Industry Accounting		17. Father's Name (First, Middle, Last) Louis Karsh			
18. Mother's Name (First, Middle, Maiden Surname) Anna Skolnick		19a. Informant's Name/Relationship (Type, Print) Mark Haflich - son			
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 22200 Zion Rd. Brookeville, MD 20833					
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Temple Ashkenaz Cem.		20c. Location - City or Town, State 1-19-04 Everett, Mass.	
21. Signature of Funeral Service Licensee Sean P. Hines		22. Name and Address of Facility Hines-Rinaldi F.H. 11800 New Hampshire Ave. Silver Spring, MD 20904			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Heart Failure Due to (or as a consequence of): b. Pneumonia Due to (or as a consequence of): c. Due to (or as a consequence of): d. Approximate Interval Between Onset and Death					
23b. IF FEMALE: Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown					
23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (Specify) <input type="checkbox"/> Unknown					
23d. Date of delivery Month Day Year					
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.					
23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown					
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No					
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M	
28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	
28f. Location (Street and Number or Rural Route Number, City or Town, State)					
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.					
29b. Signature and title of certifier DR. Denis O'Brien		29c. License number F37535		29d. Date signed (Month, Day, Year) 1/17/2004	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DR. Denis O'Brien 3414 Olandwood Ct. Olney, MD 20832					
31. Date filed (Month, Day, Year) JAN 22 2004		32. Registrar's Signature Benjamin B Sparks			

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2004 03853

Amend# 5. Per Fam.PGC 1-28-04 cr

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than 'natural', or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

Physician
/Medical
ExaminerFuneral
Director

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

1. Decedent's Name (First, Middle, Last) Margaret Wheeler Harrod		2. Date of Death Month January Day 18 Year 2004		3. Time of Death 5:30AM	
4a. Facility Name (If not institution, give street and number) Prince Georges Hospital			4b. City, Town, or Location of Death Cheverly		4c. County of Death Prince George
5. Social Security Number 023-46-0512	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 49 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) June 10, 1954
9. Birthplace (State or Foreign Country) Wash, D.C.					
Usual Residence of Decedent					
10a. State Maryland	10b. County Prince George	10c. City, Town or Location Riverdale		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
10e. Street and Number 6708 Auburn Avenue		10f. Zip Code 20737		10g. Citizen of What Country? United States	
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:	
14. Race - American Indian, Black, White, etc. Specify: Black					
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 2		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Management Analyst		16b. Kind of Business/Industry Federal Government	
17. Father's Name (First, Middle, Last) Robert Hardy			18. Mother's Name (First, Middle, Maiden Surname) Margaret Green		
19a. Informant's Name/Relationship (Type, Print) Roy Harrod/Spouse			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6708 Auburn Avenue, Riverdale, MD. 20737		
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Fort Lincoln Cemetery		20c. Location - City or Town, State 01/23/2004 Brentwood, MD.	
21. Signature of Funeral Service Licensee 		22. Name and Address of Facility Pope Funeral Homes 5538 Marlboro Pk. Forestville, MD. 20747			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. ARTERIOSCLEROTIC CARDIOVASCULAR Disease Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last					Approximate Interval Between Onset and Death years
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Cardio Respiratory Arrest with Anoxic Encephalopathy Diabetes mellitus					23b. Did tobacco use contribute to the causa of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown
24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No					24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M	
28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred			
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) 1. <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.					
29b. Signature and title of certifier 		29c. License number D01852		29d. Date signed (Month, Day, Year) JANUARY 19 2004	
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) Donald George, M.D. 7305 A-Hanover Pkwy Greenbelt, MD 20770					
31. Date filed (Month, Day, Year) JAN 21 2004		32. Registrar's Signature 			

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2004 03854

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Ella Mae Howard

2. Date of Death

January 10, 2004

3. Time of Death

3:29 AM

4a. Facility Name (If not institution, give street and number)

Prince George's Hospital Center

4b. City, Town, or Location of Death

Cheverly

4c. County of Death

Prince George's

5. Social Security Number

578-86-8991

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

82 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

September 12, 1921

9. Birthplace (State or Foreign Country)

South Carolina

Usual Residence of Decedent

10a. State

Maryland

10b. County

Prince George's

10c. City, Town or Location

Temple Hills

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

4012 28th Avenue Apt. #202

10f. Zip Code

20748

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

10th grade

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Unemployed

16b. Kind of Business/Industry

N/A

17. Father's Name (First, Middle, Last)

Sydney Peoples

18. Mother's Name (First, Middle, Maiden Surname)

Sue Ellen Weary

19a. Informant's Name/Relationship (Type, Print)

Ernestine H. Lowery (Daughter)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

4012 28th Avenue Apt. #202 Temple Hills, Maryland 20748

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Hamory Memorial Park

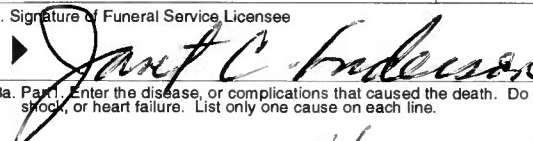
Date

1/17/04

20c. Location - City or Town, State

Landover, Maryland

21. Signature of Funeral Service Licensee



22. Name and Address of Facility

ROLLINS FUNERAL HOME, INC.

4339 HUNT PL. N.E. WASHINGTON, D.C. 20019

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Hypertensive Cardiovascular disease

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Sepsis

Due to (or as a consequence of):

c. Respiratory Failure

Due to (or as a consequence of):

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient2 ☒ ER/Outpatient3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier



29c. License number

D31528

29d. Date signed (Month, Day, Year)

1/12/04

30. Name and address of person who completed cause of death (from 23a) (Type, Print)

Margaret A. Ryan, M.D. 6128 Landover Road Cheverly, Maryland 20785

31. Date filed (Month, Day, Year)

JAN 21 2004

32. Registrar's Signature



State Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2004 03855

1- For State Registrar

Certificate of Death

Reg. No.

Physician / Medical Examiner	1. Decedent's Name (First, Middle, Last) David Donnell Honesty				2. Date of Death Month Day Year JANUARY 1, 2004		3. Time of Death M 1058 A	
	4a. Facility Name (If not institution, give street and number) S. ANVIL LANE @ OXON RUN DRIVE				4b. City, Town, or Location of Death HILLCREST HEIGHTS		4c. County of Death PRINCE GEORGES	
Funeral Director	5. Social Security Number 577-02-9204		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 24 Yrs.		8. Date of Birth (Month, Day, Year) August 21, 1979	
	9. Birthplace (State or Foreign Country) Washington DC		10a. State DC		10b. County Washington		10c. City, Town or Location Washington	
To Be Completed by Funeral Director	10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No				10e. Street and Number 700 12th St #309 SE		10f. Zip Code 20003	
	10g. Citizen of What Country? United States				11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
To Be Completed by Physician/Medical Examiner	13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: Black		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+)	
	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Food Service				16b. Kind of Business/Industry Private			
To Be Completed by Physician/Medical Examiner	17. Father's Name (First, Middle, Last) Edward Covington				18. Mother's Name (First, Middle, Maiden Surname) Bronwyn Honesty			
	19a. Informant's Name/Relationship (Type, Print) Bronwyn Honesty/ Mother				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 700 12th St SE #309 Washington DC 20003			
To Be Completed by Physician/Medical Examiner	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Resurrection Cemetery		20c. Location - City or Town, State Clinton MD	
	21. Signature of Funeral Service Licensee Salonia Malavis				22. Name and Address of Facility Alexander S. Pope Funeral Home 2617 Penn Ave SE Washington DC 20020			
Physician / Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. MULTIPLE GUNSHOT WOUNDS						Approximate Interval Between Onset and Death	
	23b. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23c. Date of delivery Month Day Year	
To Be Completed by Physician/Medical Examiner	24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No						24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
	25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No						26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) AT SCENE	
To Be Completed by Physician/Medical Examiner	27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year) 11/04 FOUND		28b. Time of Injury 1043 AM		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	28d. Describe how injury occurred SUBJECT SHOT		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) FOUND IN FIELD		28f. Location (Street and Number or Rural Route Number, City or Town, State) FOUND SOUTH ANVIL LANE AND OXON RUN DRIVE HILLCREST HEIGHTS			
To Be Completed by Physician/Medical Examiner	29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.						29b. Signature and title of certifier [Signature]	
	29c. License number OCME						29d. Date signed (Month, Day, Year) JANUARY 2, 2004	
To Be Completed by Physician/Medical Examiner	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Mary G. Ripple, M.D. 111 Penn Street, Baltimore, Maryland 21201						31. Date filed (Month, Day, Year) JAN 21 2004	
	32. Registrar's Signature [Signature]						33. Date of Death JAN 21 2004	

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural," or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2004 03856

1- For
State
RegistrarPhysician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Kenneth Evanston Henson

2. Date of Death

January 16, 2004

3. Time of Death

0748 P.M.

Funeral
Director

4a. Facility Name (If not institution, give street and number)

Washington Adventist Hospital

4b. City, Town, or Location of Death

Takoma

4c. County of Death

Montgomery

5. Social Security Number

578-90-1705

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

43 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Dec. 11, 1960

9. Birthplace (State or Foreign Country)

Wash., DC

Usual Residence of Decedent

10a. State

Md.

10b. County

Montgomery

10c. City, Town or Location

Silver Spring

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

13701 Modrad Way

10f. Zip Code

20910

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Customer Service Rep.

16b. Kind of Business/Industry

Ikea

17. Father's Name (First, Middle, Last)

Cornelius Henson

18. Mother's Name (First, Middle, Maiden Surname)

Lorraine Archie

19a. Informant's Name/Relationship (Type, Print)

Dell Henson/wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

13701 Modrad Way
Silver Spring, Md. 20910

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Ft. Lincoln Cem.

Date

1/22/04

20c. Location - City or Town, State

Brentwood, Md.

21. Signature of Funeral Service Licensee

Janice Edwards

22. Name and Address of Facility

Hodges & Edwards F.H.
3910 Silver Hill Rd., Suitland, Md. 210746

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. CORONARY THROMBOSIS

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. ATHEROSCLEROTIC CARDIOVASCULAR DISEASE

Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☐ No
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 5 ☐ Other (specify)
9 ☐ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an autopsy performed?
1 ☒ Yes 2 ☐ No24b. Were autopsy findings available prior to completion of cause of death?
1 ☒ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☒ Yes 2 ☐ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient2 ☒ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation
2 ☐ Accident 6 ☐ Could not be determined
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Margaret McKeel MD

29c. License number

O.C.M.E.

29d. Date signed (Month, Day, Year)

January 17, 2004

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

N. KOREU

111 Penn Street, Baltimore, Maryland 21201

31. Date filed (Month, Day, Year)

JAN 21 2004

32. Registrar's Signature

[Signature]

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
ExaminerTo the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2004 03857

1- For
State
RegistrarPhysician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Vincella

Howell

2. Date of Death

January 18, 2004

3. Time of Death

5:55 A M

4a. Facility Name (If not institution, give street and number)

Crofton Convalescent Center

4b. City, Town, or Location of Death

Crofton

4c. County of Death

Anne Arundel

Funeral
Director

5. Social Security Number

071-26-2343

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

81 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

June 2, 1922

9. Birthplace (State or Foreign Country)

Jamaica, WI

Usual Residence of Decedent

10a. State
Maryland10b. County
Anne Arundel

10c. City, Town or Location

Crofton

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

1482 Lowell Court

10f. Zip Code

21114

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

6

College (1-4or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Nurse's Assistant

16b. Kind of Business/Industry

Private

17. Father's Name (First, Middle, Last)

Sir Bradford

18. Mother's Name (First, Middle, Maiden Surname)

Elsada Williams

19a. Informant's Name/Relationship (Type, Print)

Shirley Tracey Holmes (Daughter)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

937 Pleasant Hill Lane Bowie, MD 20716

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Resurrection

Date

Jan. 23, 04

20c. Location - City or Town, State

Clinton, Maryland 20735

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Jordan Funeral Service, Inc.

4001 Benning RD, NE 20019 Washington, DC

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Atherosclerotic Heart Disease

Years

Due to (or as a consequence of):

b. Dementia

Years

Due to (or as a consequence of):

c. Hypertensive Heart Disease

Years

Due to (or as a consequence of):

d.

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☒ No
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown3 ☐ Ectopic pregnancy5 ☐ Other (Specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

History Of Strokes

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Rakesh Arora, MD 14300 Gallant Fox Lane Suite 222 Bowie, MD 20715

31. Date filed (Month, Day, Year)

JAN 20 2004

32. Registrar's Signature

Rakesh Arora

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transitState
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2004 03858

1- For State Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) GREGORY HAMMOND		2. Date of Death Month Day Year January 16, 2004		3. Time of Death 23:09 M
	4a. Facility Name (If not institution, give street and number) Prince George's Hospital Center		4b. City, Town, or Location of Death Cheverly		4c. County of Death Prince George's
Funeral Director	5. Social Security Number 577-78-7712	6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F	7. Age (In yrs. last birthday) 46 Yrs.	8. Date of Birth (Month, Day, Year) 4 29 1957	9. Birthplace (State or Foreign Country) MARYLAND
	Usual Residence of Decedent				
	10a. State MD	10b. County PRINCE GEORGE'S	10c. City, Town or Location SEAT PLEASANT		10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No
	10e. Street and Number 6304 SEAT PLEASANT DRIVE		10f. Zip Code 20743	10g. Citizen of What Country? U.S.A.	
	11. Marital Status 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:	13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: BLACK
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12th College (1-4 or 5+) _____		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) AIR CONDITION & HEAT TECH.		16b. Kind of Business/Industry PRIVATE
	17. Father's Name (First, Middle, Last) CLARENCE D. HAMMOND SR.		18. Mother's Name (First, Middle, Maiden Surname) JULIA CARPENTER		
	19a. Informant's Name/Relationship (Type, Print) JEANNE A. CARPENTER/AUNT		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 200 RHODE ISLAND AVENUE N.E. WASHINGTON, DC 20002		
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) HARMONY CEMETERY	Date 1-23-04	20c. Location - City or Town, State LANDOVER, MARYLAND
	21. Signature of Funeral Service Licensee K. D. Marshall		22. Name and Address of Facility J. B. JENKINS FUNERAL HOME 7474 LANDOVER ROAD LANDOVER, MARYLAND 20785		
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Atherosclerotic Cardiovascular Disease Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of):				Approximate Interval Between Onset and Death
	23b. IF FEMALE: Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown 23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) 9 <input type="checkbox"/> Unknown				23d. Date of delivery Month Day Year
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown
	24a. Was an autopsy performed? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No
	25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No	26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined	28a. Date of Injury (Month, Day, Year)	28b. Time of Injury M	28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	28d. Describe how injury occurred
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)
	29a. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				
	29b. Signature and title of certifier Kenneth Marshall MD		29c. License number O.C.M.E.		29d. Date signed (Month, Day, Year) January 18, 2004
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MARYLAND A. KOREN 111 Penn Street, Baltimore, Maryland 21201				
State Registrar	31. Date filed (Month, Day, Year) JAN 23 2004		32. Registrar's Signature Brian T. Spore		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2004 03859

1- For State Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Jeanne M. Imbriale				2. Date of Death Month Day Year January 17, 2004				3. Time of Death 4:40 a.m.					
	4a. Facility Name (If not institution, give street and number) Lorien Nursing and Rehabilitation Ctr				4b. City, Town, or Location of Death Mount Airy				4c. County of Death Carroll					
Funeral Director	5. Social Security Number 208-07-1026		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 89 Yrs.		If Under 1 Year Months Days		If Under 24 Hrs. Hours Min.		8. Date of Birth (Month, Day, Year) March 2, 1914		9. Birthplace (State or Foreign Country) Pennsylvania	
	Usual Residence of Decedent													
10a. State Maryland		10b. County Carroll		10c. City, Town or Location Mount Airy						10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				
10e. Street and Number 713 Midway Avenue						10f. Zip Code 21771				10g. Citizen of What Country? USA				
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:			13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: White				
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 12						16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Sales				16b. Kind of Business/Industry Medical				
17. Father's Name (First, Middle, Last) Hayden James Seifert								18. Mother's Name (First, Middle, Maiden Surname) Elizabeth King						
19a. Informant's Name/Relationship (Type, Print) Ryan J. Imbriale/grandson								19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) PO Box 11, Timonium, MD 21094						
20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Metropolitan Crematory				Date 01/18/04		20c. Location - City or Town, State Alexandria, VA				
21. Signature of Funeral Service Licensee Eva S. Scarlo								22. Name and Address of Facility Francis J. Collins Funeral Home 500 University Blvd, W, Silver Spring, MD 20901						
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.														
Immediate Cause (Final disease or condition resulting in death)														
a. Congestive Heart Failure Due to (or as a consequence of):														
b. Coronary Artery Disease Due to (or as a consequence of):														
c. COPD Due to (or as a consequence of):														
d.														
Approximate Interval Between Onset and Death months														
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 9 <input type="checkbox"/> Unknown														
23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify)														
23d. Date of delivery Month Day Year														
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.										23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown				
										24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				
										24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No				
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)										
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide				28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred				
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)						28f. Location (Street and Number or Rural Route Number, City or Town, State)								
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.														
29b. Signature and title of certifier S. Gupta M.D.								29c. License number D0053150				29d. Date signed (Month, Day, Year) January 18, 2004		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Shakunmala Gupta, M.D. 201-109 BACK RIVER NECK ROAD BALTIMORE, MARYLAND														
31. Date filed (Month, Day, Year) JAN 21 2004				32. Registrar's Signature S. Sparks										

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

1- For
State
Registrar

2004 03860

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Lillie Louise Joyner				2. Date of Death Month Day Year January 21, 2004		3. Time of Death 10:05 a M	
	4a. Facility Name (If not institution, give street and number) Genesis Eldercare-Layhill Center				4b. City, Town, or Location of Death Silver Spring		4c. County of Death Montgomery	
Funeral Director	5. Social Security Number 409-32-5286	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 85 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) May 7, 1918		9. Birthplace (State or Foreign Country) Tennessee
	Usual Residence of Decedent							
10a. State Maryland		10b. County Prince George's		10c. City, Town or Location Largo			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
10e. Street and Number 9715 Summit Circle, Apt. 2E				10f. Zip Code 20774		10g. Citizen of What Country? USA		
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: Black	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) Clerk				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Clerk			16b. Kind of Business/Industry Department Store	
17. Father's Name (First, Middle, Last) U.T. Sandridge				18. Mother's Name (First, Middle, Maiden Surname) Bertha Payne				
19a. Informant's Name/Relationship (Type, Print) Cheri J. Koger/ Daughter				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9715 Summit Circle Apt. 2E, Largo, MD 20774				
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Metropolitan Crematory		Date January 22 2004		20c. Location - City or Town, State Alexandria, Virginia
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility Francis J. Collins Funeral Home Inc. 500 University Blvd. W. Silver Spring, MD 20901				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Failure To Thrive Due to (or as a consequence of): b. Dementia Due to (or as a consequence of): c. Due to (or as a consequence of): d.								Approximate Interval Between Onset and Death Months Years
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown				23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <input type="checkbox"/> Unknown				23d. Date of delivery Month Day Year
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)				
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								29b. Signature and title of certifier 
29c. License number D38262				29d. Date signed (Month, Day, Year) January 22, 2004				
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Anurita Mendhiratta M.D. 2401 Research Blvd. Suite 330, Rockville, MD 20850								
31. Date filed (Month, Day, Year) JAN 23 2004				32. Registrar's Signature 				

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification; To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2004 03861

1- For State Registrar

AMEND#26 per MD/23/04 BW, McCo

Certificate of Death

Reg. No.

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified as once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Physician /Medical Examiner

Funeral Director

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

1. Decedent's Name (First, Middle, Last) Edmund N. Jones		2. Date of Death Month 1 Day 12 Year 2004		3. Time of Death 9:00 P. M	
4a. Facility Name (If not institution, give street and number) Casey House		4b. City, Town, or Location of Death Rockville		4c. County of Death Montgomery	
5. Social Security Number 460-68-4423	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 61 Yrs.	8. Date of Birth (Month, Day, Year) 2-6-1942	9. Birthplace (State or Foreign Country) MS	
Usual Residence of Decedent					
10a. State MD	10b. County Montgomery	10c. City, Town or Location Bethesda		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
10e. Street and Number 4801 Fairmount Ave. Apt. #607		10f. Zip Code 20814		10g. Citizen of What Country? U.S.A.	
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: 61-81		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:	
14. Race - American Indian, Black, White, etc. Specify: White		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4or 5+)			
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Management		16b. Kind of Business/Industry Gold Belt Eagle			
17. Father's Name (First, Middle, Last) Noverta Jones		18. Mother's Name (First, Middle, Maiden Surname) Ollie Muse			
19a. Informant's Name/Relationship (Type, Print) James B. Jones - Son		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4801 Fairmount Ave. #607 Bethesda, MD 20814			
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Arlington National		20c. Location - City or Town, State 2-20-04 Arlington, VA	
21. Signature of Funeral Service Licensee 		22. Name and Address of Facility Hines-Rinald F. H. 11800 New Hampshire Ave., Silver Spring, MD 20904			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Adenocarcinoma unknown primary		Approximate Interval Between Onset and Death 1 year			
Immediate Cause (Final disease or condition resulting in death)		Due to (or as a consequence of):			
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		Due to (or as a consequence of):			
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Other (specify) <input checked="" type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Unknown		23d. Date of delivery Month Day Year	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown			
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> OCA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) Hospice			
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M	
28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred			
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.					
29b. Signature and title of certifier 		29c. License number D35635		29d. Date signed (Month, Day, Year) 1-13-2004	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Joseph Kaplan, 6001 Muncaster Mill Rd. Rockville, MD 20850					
31. Date filed (Month, Day, Year) JAN 23 2004		32. Registrar's Signature 			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

1- For
State
Registrar

2004 03862

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Physician
/Medical
ExaminerFuneral
Director

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

1. Decedent's Name (First, Middle, Last) OLIVE PACE JOHNSON				2. Date of Death Month JAN. Day 20, Year 2004		3. Time of Death 3:45 P M	
4a. Facility Name (If not institution, give street and number) MONTGOMERY GENERAL HOSPITAL				4b. City, Town, or Location of Death OLNEY		4c. County of Death MONTGOMERY	
5. Social Security Number 412-05-8989		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 95 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) MARCH 15, 1908	
9. Birthplace (State or Foreign Country) TENNESSEE							
Usual Residence of Decedent							
10a. State MD.		10b. County MONTGOMERY		10c. City, Town or Location SILVER SPRING		10d. Inside City Limits <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No	
10e. Street and Number 13909 BETHPAGE LA.				10f. Zip Code 20906		10g. Citizen of What Country? U.S.A.	
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: WHITE	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) OWNER		16b. Kind of Business/Industry RESTAURANT	
17. Father's Name (First, Middle, Last) WILLIAM PACE				18. Mother's Name (First, Middle, Maiden Surname) ANNIE F. ALLEN			
19a. Informant's Name/Relationship (Type, Print) DAUGHTER- ELIZABETH N. THORNBY/ IN-LAW				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 13909 BETHPAGE LA., SILVER SPRING, MD. 20906			
20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) CHAMBERS CREMATORY		Date 1-21-2004		20c. Location - City or Town, State RIVERDALE, MD.	
21. Signature of Funeral Service Licensee W. W. Chambers M00091				22. Name and Address of Facility CHAMBERS FUNERAL HOME & CREMATORIUM, P.A. 5801 CLEVELAND AVE., RIVERDALE, MD. 20737			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. CEREBRO VASCULAR ACCIDENT Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Approximate Interval Between Onset and Death 24 HOURS							
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 9 <input type="checkbox"/> Unknown 23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) 9 <input type="checkbox"/> Unknown 23d. Date of delivery Month Day Year							
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. CORONARY VASCULAR DISEASE HYPERTENSION						23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown	
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No					
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
28d. Describe how injury occurred				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			
28f. Location (Street and Number or Rural Route Number, City or Town, State)							
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.							
29b. Signature and title of certifier Bennett Morrison M.D.				29c. License number D47682		29d. Date signed (Month, Day, Year) JAN. 20, 2004	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BENNETT MORRISON, M.D. 2901 OLNEY-SANDY SPRING RD., OLNEY, MD. 20832							
31. Date filed (Month, Day, Year) JAN 22 2004		32. Registrar's Signature Geneva B Sparks					

State
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

1- For State Registrar AVEND#23a(b) per MD1/20/2004, BW, MCGO

2004 03863

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last) John Leonard Johnson 2. Date of Death Month Day Year January 15, 2004 3. Time of Death 1315 M

Funeral
Director

4a. Facility Name (If not institution, give street and number) 11966 Andrew Street 4b. City, Town, or Location of Death Wheaton 4c. County of Death Montgomery

5. Social Security Number 579-01-9521 6. Sex 1 M 2 F 7. Age (In yrs. last birthday) 82 Yrs. 8. Date of Birth (Month, Day, Year) March 17, 1921 9. Birthplace (State or Foreign Country) Pennsylvania

Usual Residence of Decedent 10a. State Maryland 10b. County Montgomery 10c. City, Town or Location Wheaton 10d. Inside City Limits 1 Yes 2 No

10e. Street and Number 11966 Andrew Street 10f. Zip Code 20902 10g. Citizen of What Country? United States

11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates: WWII 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Yes 2 No Specify: 14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Foreman 16b. Kind of Business/Industry Furniture Refinishing

17. Father's Name (First, Middle, Last) Not Available 18. Mother's Name (First, Middle, Maiden Surname) Ursula Maiden Not Available

19a. Informant's Name/Relationship (Type, Print) Gary R. Johnson/Son 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11966 Andrew Street, Wheaton, Maryland 20902

20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 20b. Place of Disposition (Name of cemetery, crematory or other place) Gate of Heaven Cemetery Date January 21, 2004 20c. Location - City or Town, State Silver Spring, Maryland

21. Signature of Funeral Service Licensee [Signature] M01346 22. Name and Address of Facility Robert A. Pumphrey Funeral Home/ Rockville, Inc. 300 West Montgomery Avenue Rockville, Maryland 20850-2805

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Acute Myocardial Infarction Due to (or as a consequence of): Coronary Art. Dis., S/CAAG b. Coronary Artery Disease Due to (or as a consequence of): c. Due to (or as a consequence of): d. Approximate Interval Between Onset and Death Terminal

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify) 23d. Date of delivery Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Hypertension 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown

Generalized Arteriosclerosis 24a. Was an autopsy performed? 1 Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No

25. Was case referred to medical examiner? 1 Yes 2 No 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify)

27. Manner of Death 1 Natural 2 Accident 3 Suicide 4 Homicide 5 Pending investigation 6 Could not be determined 28a. Date of Injury (Month, Day Year) 28b. Time of Injury M 28c. Injury at Work? 1 Yes 2 No 28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier [Signature] 29c. License number D12121 29d. Date signed (Month, Day, Year) January 19, 2004

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) George F. Sengstack, M.D. 3929 Ferrara Drive, Wheaton, Maryland 20906-4709

31. Date filed (Month, Day, Year) JAN 20 2004 32. Registrar's Signature [Signature]

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2004 03864

1- For State Registrar

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

JANE MARIE JARBOE

2. Date of Death

Month Day Year
JANUARY 14, 2004

3. Time of Death

10:45 A M

4a. Facility Name (If not institution, give street and number)

ST VINCENT de PAUL NURSING CENTER

4b. City, Town, or Location of Death

FROSTBURG

4c. County of Death

ALLEGANY

Funeral
Director

5. Social Security Number

348-26-4869

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

70 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth (Month, Day, Year)

JULY 8, 1933

9. Birthplace (State or Foreign Country)

MISSOURI

Usual Residence of Decedent

10a. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Silver Spring

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

9727 Mount Pisgah Road #1613

10f. Zip Code

20903

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

5+

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Teacher

16b. Kind of Business/Industry

Public Schools

17. Father's Name (First, Middle, Last)

Frank I. Wehrle

18. Mother's Name (First, Middle, Maiden Surname)

Marie Theresa Saler

19a. Informant's Name/Relationship (Type, Print)

Nancy A. Jackson

Niece

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

14305 Bald Knob Road Mount Savage, Maryland 21545

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Mount Olivet

Date

Jan. 19, 2004

20c. Location - City or Town, State

Washington, DC

21. Signature of Funeral Service Licensee

Andrew J. Cole

22. Name and Address of Facility

Francis J. Collins Funeral Home, Inc.
500 University Blvd., W., Silver Spring, MD 20901

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

End Stage Cirrhosis

Approximate Interval Between Onset and Death

1 year

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

a. Due to (or as a consequence of):

Severe Hepatic Encephalopathy

1 year

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☒ No
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy
4 ☐ Pregnant at time of death 5 ☐ Other (specify)
9 ☐ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Alcoholism

Thrombocytopenia

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DQA

Other:

4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☒ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

H. Chelani

29c. License number

D58853

29d. Date signed (Month, Day, Year)

1/14/4

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

HADIS A. CHOTANI, 130 Pennsylvania Ave, Cumberland, MD 21502

31. Date filed (Month, Day, Year)

JAN 20 2004

32. Registrar's Signature

[Signature]

State Registrar

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23e or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2004 03865

1- For State Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) John E. Jennings				2. Date of Death Month January Day 8 Year 2004		3. Time of Death 1:30PM	
	4a. Facility Name (If not institution, give street and number) 3411 29th Avenue				4b. City, Town, or Location of Death Temple Hills		4c. County of Death P.G.	
Funeral Director	5. Social Security Number 577-50-8556		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 67 Yrs.		8. Date of Birth (Month, Day, Year) Jan. 29, 1936	
	9. Birthplace (State or Foreign Country) Wash., DC		10a. State Md.		10b. County P.G.		10c. City, Town or Location Temple Hills	
To Be Completed by Funeral Director	10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No				10e. Street and Number 3411 29th Avenue		10f. Zip Code 20748	
	10g. Citizen of What Country? United States				11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:	
To Be Completed by Physician/Medical Examiner	13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: Black		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+)	
	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Driver				16b. Kind of Business/Industry Private			
To Be Completed by Physician/Medical Examiner	17. Father's Name (First, Middle, Last) John S. Jennings				18. Mother's Name (First, Middle, Maiden Surname) Alice Gray			
	19a. Informant's Name/Relationship (Type, Print) Irene J. Wills/sister				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3411 29th Avenue Temple Hills, Md. 20748			
To Be Completed by Physician/Medical Examiner	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Cedar Hill Cem.		20c. Location - City or Town, State Suitland, Md.	
	21. Signature of Funeral Service Licensee Janice Edwards				22. Name and Address of Facility Hodges & Edwards F.H. 3910 Silver Hill Rd., Suitland, Md. 20746			
To Be Completed by Physician/Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Metastatic Head & Neck Cancer							Approximate Interval Between Onset and Death
	23b. Due to (or as a consequence of): 23c. Due to (or as a consequence of): 23d. Due to (or as a consequence of): 23e. Due to (or as a consequence of):							
To Be Completed by Physician/Medical Examiner	23f. IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown							23d. Date of delivery Month Day Year
	23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify)							
To Be Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown
	24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No							
To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined				28a. Date of Injury (Month, Day, Year) 1/16/04			
To Be Completed by Physician/Medical Examiner	28b. Time of Injury M				28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
	28d. Describe how injury occurred				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			
To Be Completed by Physician/Medical Examiner	28f. Location (Street and Number or Rural Route Number, City or Town, State)				29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.			
	29b. Signature and title of certifier Janice Edwards				29c. License number D52767			
To Be Completed by Physician/Medical Examiner	29d. Date signed (Month, Day, Year) 1/16/04				30. Name and address of person who completed cause of death (Item 23a) (Type, Print) H.S. SETH 50 W Edmonston Drive, #303, Rockville MD 20852			
	31. Date filed (Month, Day, Year) JAN 21 2004				32. Registrar's Signature John S. SETH			

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2004 03866

1- For
State
RegistrarPhysician
/Medical
ExaminerFuneral
Director

1. Decedent's Name (First, Middle, Last)

MATTIE JORDAN

2. Date of Death

Month Day Year
1 10 2004

3. Time of Death

2:40 P M

4a. Facility Name (If not institution, give street and number)

FUTURE CARE PINE VIEW NURSING HOME

4b. City, Town, or Location of Death

CLINTON

4c. County of Death

PRINCE GEORGE'S

5. Social Security Number

577-36-1199

6. Sex

☐ M ☒ F

7. Age (In yrs. last birthday)

84 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
11 30 1919

9. Birthplace (State or Foreign Country)

GEORGIA

Usual Residence of Decedent

10a. State

MD

10b. County

PRINCE GEORGE'S

10c. City, Town or Location

CLINTON

10d. Inside City Limits

☒ Yes ☐ No

10e. Street and Number

9101 PINEVIEW LANE

10f. Zip Code

20724

10g. Citizen of What Country?

U.S.A.

11. Marital Status

☐ Never Married ☐ Married
☒ Widowed ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
☐ Yes ☒ No
If Yes, Give
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No.
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)☐ Yes ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: BLACK

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4or 5+)

9th

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

SERVICE REPRESENTATIVE

16b. Kind of Business/Industry

PRIVATE

17. Father's Name (First, Middle, Last)

WILLER MILLER

18. Mother's Name (First, Middle, Maiden Surname)

LEE CALHOUN

19a. Informant's Name/Relationship (Type, Print)

EVELYN WILSON/DAUGHTER

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

3301 SAVILLE LANE MITCHELLVILLE, MARYLAND 20721

20a. Method of Disposition

☒ Burial ☐ Cremation ☐ Removal from State
☐ Donation ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

FT. LINCOLN CEMETERY

Date

1-20-2004

20c. Location - City or Town, State

BRENTWOOD, MARYLAND

21. Signature of Funeral Service Licensee

22. Name and Address of Facility J.B. JENKINS FUNERAL HOME

7474 LANDOVER ROAD LANDOVER, MARYLAND 20785

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

a. HYPERTENSIVE CARDIOVASCULAR DISEASE

Due to (or as a consequence of):

b. HYPERTENSION

Due to (or as a consequence of):

c. PARKINSON'S DISEASE

Due to (or as a consequence of):

d. ANEMIA

Approximate
Interval Between
Onset and Death

IF FEMALE:

23b. Was decedent pregnant
in the past 12 months?☐ Yes ☒ No
☐ Unknown

23c. If yes, outcome of pregnancy

☐ Live birth ☐ Fetal death
☐ Pregnant at time of death
☐ Unknown☐ Ectopic pregnancy
☐ Other (Specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Hypothyroidism; Partial Colectomy
Septic Arthritis of Right Knee.

23e. Did tobacco use contribute to the cause of death?

☐ Yes ☒ No ☐ Probably ☐ Unknown24a. Was an
autopsy
performed?☐ Yes ☒ No24b. Were autopsy findings available
prior to completion of cause of
death?☐ Yes ☒ No25. Was case referred to medical
examiner?☐ Yes ☒ No

Hospital:

☐ Inpatient ☐ ER/Outpatient ☐ DOA

26. Place of Death (Check only one)

Other: ☒ Nursing Home ☐ Residence ☐ Other (Specify)

27. Manner of Death

☒ Natural ☐ Pending
investigation
☐ Accident ☐ Could not be
determined
☐ Suicide ☐ Homicide28a. Date of Injury
(Month, Day Year)28b. Time of
injury

M

28c. Injury at
Work?☐ Yes ☒ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
and manner stated.

29b. Signature and title of certifier

29c. License number

D 44044

29d. Date signed (Month, Day, Year)

1-19-04

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

JONATHAN THOMPSON, MD 7111 Allentown Rd, Ste 101, Fort Washington MD 20744

31. Date filed (Month, Day, Year)

JAN 21 2004

32. Registrar's Signature

State
Registrar

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 21 is marked other than "natural", or items 23a or 28a-f show
any injury or other traumatic event, the Medical Examiner must be notified at
once.To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2004 03867

1- For
State
RegistrarPhysician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Nikolas Josphe Jackson

2. Date of Death

January 15, 2004

3. Time of Death

3:42pm M

4a. Facility Name (If not institution, give street and number)

Anne Arundel Medical Center

4b. City, Town, or Location of Death

Annapolis

4c. County of Death

Anne Arundel

Funeral
Director

5. Social Security Number

None

6. Sex

XXM 2□F

7. Age (In yrs. last birthday)

Yrs.

If Under 1 Year

Months

Days

2

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

(Month, Day, Year)

January 13, 2004 Maryland

9. Birthplace (State or Foreign Country)

Usual Residence of Decedent

10a. State

MD

10b. County

Prince Georges

10c. City, Town or Location

Bowie

10d. Inside City Limits

1□Yes 2□No

10e. Street and Number

3805 Early Glow Lane

10f. Zip Code

20716

10g. Citizen of What Country?

United States

11. Marital Status

XX Never Married 2□ Married

3□ Widowed 4□ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1□ Yes 2□ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1□ Yes 2□ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: Black

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

0

College (1-4 or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

N/A

16b. Kind of Business/Industry

17. Father's Name (First, Middle, Last)

Lerome Demetrius Jackson

18. Mother's Name (First, Middle, Maiden Surname)

Nikki Brown

19a. Informant's Name/Relationship (Type, Print)

Lerome D. Jackson /Father

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

3805 Early Glow Lane, Bowie, MD 20716

20a. Method of Disposition

1□ Burial 2□ Cremation 3□ Removal from State

4□ Donation 5□ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Harmony Mem Park

Date

1-24-04

20c. Location - City or Town, State

Landover, MD

21. Signature of Funeral Service Licensee

Alexia M. Davis

22. Name and Address of Facility

Alexander S. Pope Funeral Home

2617 Penn. Ave S.E. Washington DC 20020

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Hypoxic Ischemic Encephalopathy

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

36 hrs

Sequentially list conditions,

if any, leading to immediate cause.

Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1□ Yes 2□ No

9□ Unknown

23c. If yes, outcome of pregnancy

1□ Live birth 2□ Fetal death

4□ Pregnant at time of death

9□ Unknown

3□ Ectopic pregnancy

5□ Other (specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1□ Yes 2□ No 3□ Probably 4□ Unknown

24a. Was an autopsy performed?

1□ Yes 2□ No

24b. Were autopsy findings available prior to completion of cause of death?

1□ Yes 2□ No

25. Was case referred to medical examiner?

1□ Yes 2□ No

Hospital:

1□ Inpatient

2□ ER/Outpatient

3□ DOA

Other:

4□ Nursing Home

5□ Residence

6□ Other (Specify)

27. Manner of Death

1□ Natural

2□ Accident

3□ Suicide

4□ Homicide

5□ Pending investigation

6□ Could not be determined

28a. Date of Injury

(Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1□ Yes 2□ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

26. Place of Death (Check only one)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier

(Check only one)

1□ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2□ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Suzanne Rindfleisch DO

29c. License number

H 42733

29d. Date signed (Month, Day, Year)

January 16, 2004

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Suzanne Rindfleisch DO, AAMC, 2001 Medical Pkwy, Annapolis, Md. 21401

31. Date filed (Month, Day, Year)

JAN 21 2004

32. Registrar's Signature

Kurt & Spill

State
Registrar

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
ExaminerTo the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2004 03868

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Mary Louise Jackson				2. Date of Death Month January Day 14 , Year 2004		3. Time of Death 9:00 PM		
	4a. Facility Name (If not institution, give street and number) Heartland Health Care Center-Adelphi				4b. City, Town, or Location of Death Adelphi		4c. County of Death Prince Georges		
Funeral Director	5. Social Security Number 578-40-5284	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 71 Yrs.	If Under 1 Year Months	If Under 24 Hrs. Hours	8. Date of Birth (Month, Day, Year) July 11, 1932	9. Birthplace (State or Foreign Country) South Carolina		
	Usual Residence of Decedent				10a. State Maryland		10b. County Prince George's		
To Be Completed by Funeral Director	10c. City, Town or Location Clinton				10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No				
	10e. Street and Number 9608 Beverly Avenue				10f. Zip Code 20735		10g. Citizen of What Country? USA		
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: African American		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 11 College (1-4or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Housewife		16b. Kind of Business/Industry Private				
	17. Father's Name (First, Middle, Last) Unknown				18. Mother's Name (First, Middle, Maiden Surname) Thomasena Miles				
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) Gregory G. Jackson (Son)				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9608 Beverly Avenue Clinton, MD 20735				
	20e. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Resurrection Cemetery		Date 1/21/04		20c. Location - City or Town, State Clinton, MD		
	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility Jordan Funeral Service, Inc. 4001 Benning Rd., NE Washington, DC 20019				
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last e. Arteriosclerotic Cardiovascular Disease Due to (or as a consequence of): b. _____ Due to (or as a consequence of): c. _____ Due to (or as a consequence of): d. _____							Approximate Interval Between Onset and Death	
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Dementia End Stage Renal Disease Peripheral Vascular Disease							23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown	
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred	
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier 		29c. License number D01852		29d. Date signed (Month, Day, Year) January 15, 2004			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Paul A. DeVore, MD 4203 Queensbury Road Hyattsville, MD 20781									
31. Date filed (Month, Day, Year) JAN 20 2004		32. Registrar's Signature 							

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

6

State
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2004 03869

1- For
State
RegistrarPhysician
/Medical
ExaminerFuneral
Director

1. Decedent's Name (First, Middle, Last) MARY ELIZABETH JONES		2. Date of Death Month January Day 13 Year 2004		3. Time of Death 8:00AM M	
4a. Facility Name (If not institution, give street and number) Renee's House Assisted Living Facility		4b. City, Town, or Location of Death Bowie		4c. County of Death Prince George's	
5. Social Security Number 220-07-4530	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 81 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) February 12, 1922
9. Birthplace (State or Foreign Country) Maryland					
Usual Residence of Decedent					
10a. State MD	10b. County Prince George's	10c. City, Town or Location Bowie		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
10e. Street and Number 12323 Whitehall Drive		10f. Zip Code 20715		10g. Citizen of What Country? USA	
11. Marital Status unknown <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:	
14. Race - American Indian, Black, White, etc. Specify: Black					
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) unknown College (1-4 or 5+) unknown		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) unknown		16b. Kind of Business/Industry unknown	
17. Father's Name (First, Middle, Last) Ashberry Jones		18. Mother's Name (First, Middle, Maiden Surname) Ida (maiden name unknown)			
19a. Informant's Name/Relationship (Type, Print) Dorothy Blount/Guardianship Specialist		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5012 Rhode Island Ave. Hyattsville, MD 20781			
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Metropolitan Crematory		20c. Location - City or Town, State Alexandria, VA	
21. Signature of Funeral Service Licensee 		22. Name and Address of Facility Cedar Hill Funeral Home, Inc. 4111 Pennsylvania Ave. Suitland, MD 20746			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Arrhythmia Due to (or as a consequence of): b. Emphysema, advanced Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last					Approximate Interval Between Onset and Death Sudden Decades
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Pregnant at time of death <input checked="" type="checkbox"/> Unknown		23d. Date of delivery Month Day Year	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Senile dementia					23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) Assist. Liv.			
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M	
28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred			
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.					
29b. Signature and title of certifier 		29c. License number D22780		29d. Date signed (Month, Day, Year) 1/16/2004	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Peter M. Schissler, M.D. 7500 Greenway Center Drive, Greenbelt, MD 20770					
31. Date filed (Month, Day, Year) JAN 20 2004		32. Registrar's Signature 			

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0036
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.Physician
/Medical
ExaminerDivision of Vital Records, P.O. Box 68760,
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene
 1- For State Registrar Amend Item #206 per FH 6828 2719/04 tas Certificate of Death Reg. No. 2004 03870

Physician / Medical Examiner
 Funeral Director

1. Decedent's Name (First, Middle, Last) Otho Thomas Jarratt, III		2. Date of Death Month Day Year January 19, 2004		3. Time of Death 1:08 p M	
4a. Facility Name (If not institution, give street and number) Anne Arundel Medical Center		4b. City, Town, or Location of Death Annapolis		4c. County of Death Anne Arundel	
5. Social Security Number 219-48-4793	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 56 Yrs.	8. Date of Birth (Month, Day, Year) Oct 18, 1947	9. Birthplace (State or Foreign Country) Washington DC	
10a. State Maryland		10b. County Anne Arundel		10c. City, Town or Location Lothian	
10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		10e. Street and Number 71 Patuxent Mobile Estate		10f. Zip Code 20711	
10g. Citizen of What Country? USA		11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: 67-69	
13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 12	
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Stock Manager		16b. Kind of Business/Industry Grocery		17. Father's Name (First, Middle, Last) Otho Thomas Jarratt	
18. Mother's Name (First, Middle, Maiden Surname) Helen Louise Rhodes		19a. Informant's Name/Relationship (Type, Print) Melissa Jarratt/Wife		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 71 Patuxent Mobile Estate, Lothian, MD 20711	
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Cheltenham Vet. Cem.		20c. Location - City or Town, State Cheltenham, MD	
21. Signature of Funeral Service Licensee Myelin T. Klobert MO 322		22. Name and Address of Facility Fort Lincoln FH 3401 Bladensburg Rd, Brentwood MD		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sepsis Due to (or as a consequence of): Pneumonia Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):	
23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Other (specify) <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Unknown		23d. Date of delivery Month Day Year	
23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined	
28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)	
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier Aimee Yu MD		29c. License number D55187	
29d. Date signed (Month, Day, Year) 1/19/04		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Aimee Yu 2001 Medical Parkway Annapolis, MD 21401		31. Date filed (Month, Day, Year) JAN 22 2004	
32. Registrar's Signature [Signature]					

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2004 03871

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Elaine Jackson				2. Date of Death Month Day Year 01 13 04		3. Time of Death 11:20A.M.	
	4a. Facility Name (If not institution, give street and number) Mariner Health Care Center of Bethesda				4b. City, Town, or Location of Death Bethesda		4c. County of Death Montgomery	
Funeral Director	5. Social Security Number 577-32-9430		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 78		8. Date of Birth (Month, Day, Year) 09 27 25	
	9. Birthplace (State or Foreign Country) Lynchburg, VA.		10a. State D.C.		10b. County Washington		10c. City, Town or Location Washington	
To Be Completed by Funeral Director	10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		10e. Street and Number 5208 12th. Street N.E.		10f. Zip Code 20011		10g. Citizen of What Country? USA	
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: Black	
To Be Completed by Physician/Medical Examiner	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Supervisor		16b. Kind of Business/Industry U.S. Post Office			
	17. Father's Name (First, Middle, Last) Walter T. Scott, Sr.				18. Mother's Name (First, Middle, Maiden Surname) Lillie Belle Smith			
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) James A. Phelps Son				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 350 Richmond Terrace, Staten Island, N.Y. 10301			
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Fort Lincoln Cemetery		20c. Location - City or Town, State 1-22-04 Brentwood, MD.		20d. Date	
To Be Completed by Physician/Medical Examiner	21. Signature of Funeral Service Licensee J.P. Marshall				22. Name and Address of Facility Marshall's Funeral Home 4217 9th. St. N.W. Washington, D.C. 20011			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. CARDIAC ARRHYTHMIA Due to (or as a consequence of): b. CORONARY ARTERY DISEASE Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last				Approximate Interval Between Onset and Death 20 MINUTES YEARS			
To Be Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. CANCER OF PANCREAS				23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown			
	24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
To Be Completed by Physician/Medical Examiner	28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.							
To Be Completed by Physician/Medical Examiner	29b. Signature and title of certifier P. Zeeva, M.D.				29c. License number D-36552		29d. Date signed (Month, Day, Year) JANUARY 13 2004	
	30. Name and address of person who completed cause of death (Item 23e) (Type, Print) P. TALWAR, 5001 Edmonston Drive #401, Rockville MD 20852							
To Be Completed by Physician/Medical Examiner	31. Date filed (Month, Day, Year) JAN 23 2004				32. Registrar's Signature [Signature]			
	33. State Registrar CR (5)							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2004 03872

1- For
State
RegistrarPhysician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

NELLIE

KERR

2. Date of Death

Month

Day

Year

JAN

19

2004

3. Time of Death

2:30

A M

4a. Facility Name (If not institution, give street and number)

NATIONAL NAVAL MEDICAL CENTER

4b. City, Town, or Location of Death

BETHESDA

4c. County of Death

MONTGOMERY

5. Social Security Number

373-20-5984

6. Sex

1 ☐ M 2 ☒ F

7. Age (in yrs. last birthday)

85

Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

(Month, Day, Year)
Feb. 24, 1918

9. Birthplace (State or Foreign Country)

Indiana

Usual Residence of Decedent

10a. State

Va.

10b. County

Fairfax

10c. City, Town or Location

McLean

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

6251 Old Dominion Dr., #123

10f. Zip Code

22101

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.Specify:
White15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

4

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Tour Guide

16b. Kind of Business/Industry

Private Industry

17. Father's Name (First, Middle, Last)

Clarence Paul

18. Mother's Name (First, Middle, Maiden Surname)

Bessie Leach

19a. Informant's Name/Relationship (Type, Print)

Diana Macy / Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

490 Plaza Estival, San Clemente, CA., 92672

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Northern Va. Crematory 1-22-04 Arlington, Va.

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Arlington Funeral Home
3901 N. Fairfax Dr., Arlington, Va. 2220323a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

SEPSIS

Approximate
Interval Between
Onset and DeathSequentially list conditions,
if any, leading to immediate
cause. Enter on Jarring
Cause (Disease or injury
that initiated events
resulting in death) Last

a. Due to (or as a consequence of):

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

IF FEMALE:

23b. Was decedent pregnant
in the past 12 months?1 ☐ Yes 2 ☒ No
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy
4 ☐ Pregnant at time of death 5 ☐ Other (specify)
9 ☐ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an
autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings available
prior to completion of cause of
death?1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending
investigation
2 ☐ Accident 6 ☐ Could not be
determined
3 ☐ Suicide 4 ☐ Homicide28a. Date of Injury
(Month, Day Year)28b. Time of
Injury28c. Injury at
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

0102201465 (VA)

29d. Date signed (Month, Day, Year)

1/20/04

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

TODD R. LAROCK LCDR MC USN

NATIONAL NAVAL MEDICAL CENTER

BETHESDA MD 20889-5600

31. Date filed (Month, Day, Year)

JAN 23 2004

32. Registrar's Signature

State
Registrar

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial/transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Reg. No. 2004 03873

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar AMEND#7 per H1/23/04, BM, MCo

Certificate of Death

Reg. No. 2004 03874

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Janet G. Kohn			2. Date of Death Month Day Year January 19, 2004		3. Time of Death 11:30 M		
	4a. Facility Name (If not institution, give street and number) Shady Grove Hospital			4b. City, Town, or Location of Death Rockville		4c. County of Death Montgomery		
Funeral Director	5. Social Security Number 289-26-1590		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 74 75 Yrs.		8. Date of Birth (Month, Day, Year) Sept. 30, 1928		
	9. Birthplace (State or Foreign Country) Ohio							
To Be Completed by Funeral Director	10a. State D.C.			10b. County N/A		10c. City, Town or Location Washington		
	10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No							
	10e. Street and Number 3418 Reservoir Road N.W.			10f. Zip Code 20007		10g. Citizen of What Country? United States		
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 5+			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Attorney		16b. Kind of Business/Industry Private		
	17. Father's Name (First, Middle, Last) Ernest M. Goldrich			18. Mother's Name (First, Middle, Maiden Surname) Rose Winsberg				
	19a. Informant's Name/Relationship (Type, Print) Melvin L. Kohn (Husband)			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3418 Reservoir Road N.W. Washington, D.C. 20007				
	20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Chesapeake Crematory		Date 1-24-04		20c. Location - City or Town, State Beltsville, MD	
	21. Signature of Funeral Service Licensee			22. Name and Address of Facility Kapp Funeral And Cremation Services 935 Gist Avenue Silver Spring, MD 20910				
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Sepsis Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last							Approximate Interval Between Onset and Death 2 days
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 9 <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) 9 <input type="checkbox"/> Unknown				23d. Date of delivery Month Day Year		
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown		
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No						
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)						
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28d. Describe how injury occurred						
28f. Location (Street and Number or Rural Route Number, City or Town, State)								
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
29b. Signature and title of certifier Leo Shue M.D.			29c. License number D60557			29d. Date signed (Month, Day, Year) January 19, 2004		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Leo Shue M.D. 9901 Medical Center Drive Rockville, MD 20850								
31. Date filed (Month, Day, Year) JAN 23 2004		32. Registrar's Signature [Signature]						

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permi. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2004 03875

1- For
State
RegistrarPhysician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

ROSA Z. KRAFT

2. Date of Death

Month Day Year
JANUARY 6, 2004

3. Time of Death

3:15 P M

Funeral
Director

4a. Facility Name (If not institution, give street and number)

12320 DALEWOOD DRIVE

4b. City, Town, or Location of Death

SILVER SPRING

4c. County of Death

MONTGOMERY

5. Social Security Number

088-05-8741

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

95 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

AUGUST 1, 1908

9. Birthplace (State or Foreign Country)

POLAND

Usual Residence of Decedent

10a. State

MARYLAND

10b. County

MONTGOMERY

10c. City, Town or Location

SILVER SPRING

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

12320 DALEWOOD DRIVE

10f. Zip Code

20902

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: WHITE

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4or 5+)

2

16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired)

HOMEMAKER

16b. Kind of Business/Industry

OWN HOME

17. Father's Name (First, Middle, Last)

ISAAC

ZWERNER

18. Mother's Name (First, Middle, Maiden Surname)

FRIEDA

ARBITER

19a. Informant's Name/Relationship (Type, Print)

DANIEL KRAFT/SON

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

8201 LAKENHEATH WAY, POTOMAC, MD 20854

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Date

ADAS ISRAEL CONG. CEM. 01/09/2004 WASHINGTON, D.C.

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

Amanda Gudewig

22. Name and Address of Facility

DANZANSKY-GOLDBERG MEMORIAL CHAPELS, INC.
1170 ROCKVILLE PIKE, ROCKVILLE, MD 20852

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. HYPERTENSION

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☒ No9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death4 ☐ Pregnant at time of death9 ☐ Unknown3 ☐ Ectopic pregnancy5 ☐ Other (specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOAOther: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation2 ☐ Accident3 ☐ Suicide4 ☐ Homicide6 ☐ Could not be determined

28a. Date of Injury

(Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier
(Check only one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

P. Gupta

29c. License number

D37532

29d. Date signed (Month, Day, Year)

1/19/04

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

PRAVEEN K. GUPTA, M.D., 50 W. EDMONSTON DRIVE #202, ROCKVILLE, MARYLAND 20852

State
Registrar

31. Date filed (Month, Day, Year)

JAN 22 2004

32. Registrar's Signature

P. Gupta

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.


State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2004 03876

1- For
State
Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Anna K. Kurz				2. Date of Death Month Day Year January 16, 2004		3. Time of Death 2:00 P M	
	4a. Facility Name (If not institution, give street and number) 4514 Amherst Lane				4b. City, Town, or Location of Death Bethesda		4c. County of Death Montgomery	
Funeral Director	5. Social Security Number 219-12-4313		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 80 Yrs.		8. Date of Birth (Month, Day, Year) Feb. 3, 1923	
	9. Birthplace (State or Foreign Country) Pennsylvania		10a. State Maryland		10b. County Montgomery		10c. City, Town or Location Bethesda	
To Be Completed by Funeral Director	10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		10e. Street and Number 4514 Amherst Lane		10f. Zip Code 20814		10g. Citizen of What Country? United States	
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 2		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker		16b. Kind of Business/Industry Own Home			
	17. Father's Name (First, Middle, Last) Raymond Karge				18. Mother's Name (First, Middle, Maiden Surname) Laura Reischel			
	19a. Informant's Name/Relationship (Type, Print) Peter E. Kurz/Son				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5904 Waters Edge Road, Midlothian, Virginia 23112			
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Parklawn Memorial Park		20c. Location - City or Town, State Rockville, Maryland		20d. Date January 21, 2004	
	21. Signature of Funeral Service Licensee 		22. Name and Address of Facility Robert A. Pumphrey Funeral Home/Chase, Inc. 7557 Wisconsin Ave., Bethesda, MD 20814-3501					
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Lung cancer Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of):		23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 9 <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) 9 <input type="checkbox"/> Unknown		23d. Date of delivery Month Day Year	
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown	
	24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No					
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)						
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		
28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier 		29c. License number D51916		29d. Date signed (Month, Day, Year) Jan. 16, 2004		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Patricia Tomsko Nay, 6121 Montrose Road, Rockville, MD 20852		31. Date filed (Month, Day, Year) JAN 20 2004		32. Registrar's Signature 				

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2004 03877

1- For
State
RegistrarPhysician
/Medical
ExaminerFuneral
Director

1. Decedent's Name (First, Middle, Last)

Violet May Murhead King

2. Date of Death

January 9, 2004

3. Time of Death

5:50 A. M.

4a. Facility Name (If not institution, give street and number)

HCR/Manor Care Nursing Home

4b. City, Town, or Location of Death

Wheaton

4c. County of Death

Montgomery

5. Social Security Number

577-94-9217

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

83 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

July 20, 1920

9. Birthplace (State or Foreign Country)

Jamaica, West Indies

Usual Residence of Decedent

10a. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Silver Spring

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

2703 Randolph Road

10f. Zip Code

20902

10g. Citizen of What Country?

Jamaica, West Indies

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: Black

15. Decedent's Education
(Specify only highest grade completed)Elementary/Secondary (0-12)
8th grade

College (1-4 or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Domestic

17. Father's Name (First, Middle, Last)

William Muirhead

18. Mother's Name (First, Middle, Maiden Surname)

Ida Ambrose

19a. Informant's Name/Relationship (Type, Print)

Blossom Veronica Doyley (daughter) 2703 Randolph Road; Silver Spring, Maryland 20902

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Fort Lincoln Cemetery

Date

Jan. 17, 2004

20c. Location - City or Town, State

Brentwood, Maryland

21. Signature of Funeral Service Licensee

Karranah Chan

22. Name and Address of Facility

R. N. Horton Company Morticians, Inc.
600 Kennedy Street, N.W.; Washington, D.C. 2001123a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

Metastatic Gastric Cancer

a. Due to (or as a consequence of):

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate
Interval Between
Onset and Death

IF FEMALE:

23b. Was decedent pregnant
in the past 12 months?1 ☐ Yes 2 ☒ No
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 5 ☐ Other (Specify)
9 ☐ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an
autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings available
prior to completion of cause of
death?1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending
investigation
2 ☐ Accident 6 ☐ Could not be
determined
3 ☐ Suicide 4 ☐ Homicide28a. Date of Injury
(Month, Day Year)28b. Time of
injury28c. Injury at
Work?1 ☐ Yes 2 ☐ No28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Alan R. Segal, M.D.

29c. License number

D52261

29d. Date signed (Month, Day, Year)

January 10, 2004

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Alan R. Segal, M.D.; 1517 Hugo Circle; Silver Spring, Maryland 20906

31. Date filed (Month, Day, Year)

JAN 20 2004

32. Registrar's Signature

Bryan H. Smith

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

Im Sook Kim
04-00306
MAN

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2004 03878

1- For
State
Registrar

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) In Sook Kim		2. Date of Death Month January Day 12 Year 2004		3. Time of Death 0709 M	
	4a. Facility Name (If not institution, give street and number) Suburban Hospital		4b. City, Town, or Location of Death Bethesda		4c. County of Death Montgomery	
Funeral Director	5. Social Security Number 577-04-2631		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 58 Yrs.	
	8. Date of Birth (Month, Day, Year) Aug. 13, 1945		9. Birthplace (State or Foreign Country) Korea			
To Be Completed by Funeral Director	Usual Residence of Decedent					
	10a. State Md.		10b. County Montgomery		10c. City, Town or Location Silver Springs	
	10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No					
	10e. Street and Number 703 Buccaneer Court		10f. Zip Code 20904		10g. Citizen of What Country? U.S.A.	
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:	
	14. Race - American Indian, Black, White, etc. Specify: Asian					
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Resturant Owner		16b. Kind of Business/Industry Resturant	
	17. Father's Name (First, Middle, Last) Kwang Yong So		18. Mother's Name (First, Middle, Maiden Sumame) Soon Bok Heo			
	19a. Informant's Name/Relationship (Type, Print) Jung Kyu Kim (Daughter)		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 703 Buccaneer Ct., Silver Springs, Md. 20904			
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Norbeck Memorial		20c. Location - City or Town, State 1-16-04 Silver Springs, Md.	
21. Signature of Funeral Service Licensee Phillip Bell		22. Name and Address of Facility Phillip Bell Funeral Service 4902 Stan Haven Rd., Temple Hills, Md. 20748				
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Multiple injuries					
	Immediate Cause (Final disease or condition resulting in death) a. Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of):					
	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last					
	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input checked="" type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 4 <input type="checkbox"/> Pregnant at time of death 9 <input type="checkbox"/> Unknown		23d. Date of delivery Month Day Year	
	23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown					
	24a. Was an autopsy performed? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No					
	24b. Were autopsy findings available prior to completion of cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No					
	25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No					
	26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> R/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year) 11/2/04		28b. Time of Injury 625 A M	
28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		28d. Describe how injury occurred Subject struck by car		28e. Location (Street and Number or Rural Route Number, City or Town, State) Silver Springs, MD Eldridge Dr and New Hampshire Ave		
29a. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.						
29b. Signature and title of certifier Zabihullah Ali		29c. License number O.C.M.E.		29d. Date signed (Month, Day, Year) January 13, 2004		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ZABILLAH ALI 111 Penn Street, Baltimore, Maryland 21201						
31. Date filed (Month, Day, Year) JAN 14 2004		32. Registrar's Signature Brand & Spill				

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

State
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2004 03879

1- For
State
RegistrarPhysician
/Medical
ExaminerFuneral
Director

1. Decedent's Name (First, Middle, Last)

ALVIN ABBY KOHNE

2. Date of Death

JAN 5, 2004

3. Time of Death

6:19 P M

4a. Facility Name (If not institution, give street and number)

CIVISTA MEDICAL CENTER

4b. City, Town, or Location of Death

LAPLATA

4c. County of Death

CHARLES

5. Social Security Number

227-48-8900

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

63 Yrs.

If Under 1 Year

Months

If Under 24 Hrs.

Days

8. Date of Birth

6-18-1940

9. Birthplace (State or Foreign Country)

MARYLAND

Usual Residence of Decedent

10a. State

VA

10b. County

KING GEORGE

10c. City, Town or Location

KING GEORGE

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

16476 SCHOOLHOUSE RD

10f. Zip Code

22485

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: WHITE

15. Decedent's Education
(Specify only highest grade completed)Elementary/Secondary (0-12)
8TH

College (14 or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

TRUCK DRIVER

16b. Kind of Business/Industry

TRUCKING

17. Father's Name (First, Middle, Last)

ORVEL A. KOHNE

18. Mother's Name (First, Middle, Maiden Summa)

REEDY HEBNER

19a. Informant's Name/Relationship (Type, Print)

MARY KOHNE (SPOUSE)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

16476 SCHOOLHOUSE RD KING GEORGE VA 22485

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

NATIONAL FH CREMATORY 1/18/04

Date

20c. Location - City or Town, State

FALLS CHURCH VA

21. Signature of Funeral Service Licensee

Rogers & Maron

22. Name and Address of Facility

6600 S KINGS HWY ALEX VA

AFFORDABLE FUNERAL SERVICE

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)a. CEREBRAL VASCULAR ACCIDENT
Due to (or as a consequence of):
HYPERTENSIONSequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Lastb. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d.Approximate
Interval Between
Onset and Death

IF FEMALE:

23b. Was decedent pregnant
in the past 12 months?
1 ☐ Yes 2 ☐ No
9 ☐ Unknown23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy
4 ☐ Pregnant at time of death 5 ☐ Other (specify)
9 ☐ Unknown23d. Date of delivery
Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown24a. Was an
autopsy
performed?
1 ☐ Yes 2 ☒ No24b. Were autopsy findings available
prior to completion of cause of
death?
1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?
1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☒ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending
investigation
2 ☐ Accident 6 ☐ Could not be
determined
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury

(Month, Day Year)

28b. Time of
Injury

M

28c. Injury at
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
and manner stated.

29b. Signature and title of certifier

George Wathen MD

29c. License number

20629

29d. Date signed (Month, Day, Year)

1/6/04

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DR. GEORGE WATHEN 11345 PEMBROOKE SQ SUITE 103 WALDORF MD 20603

31. Date filed (Month, Day, Year)

JAN 22 2004

32. Registrar's Signature

Kendra L. Apple

State
Registrar

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show
any injury or other traumatic event, the Medical Examiner must be notified at
once.To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2004 03880

1- For
State
RegistrarPhysician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

George V. Loonam II

2. Date of Death

Month Day Year
January 19, 20043. Time of Death
2:45 PM

4a. Facility Name (If not institution, give street and number)

Washington Adventist Hospital

4b. City, Town, or Location of Death

Takoma Park

4c. County of Death

Montgomery

Funeral
Director

5. Social Security Number

095-28-2938

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

67 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
Apr. 25, 1936

9. Birthplace (State or Foreign Country)

New York

Usual Residence of Decedent

10a. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Silver Spring

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

816 Easley Street, #1021

10f. Zip Code

20910

10g. Citizen of What Country?

USA

11. Marital Status

1 ☒ Never Married 2 ☐ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☒ Yes 2 ☐ No
If Yes, Give
Year or Dates: Unknown13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: White

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Florist

16b. Kind of Business/Industry

Floral Design

17. Father's Name (First, Middle, Last)

Walter L. Loonam Sr.

18. Mother's Name (First, Middle, Maiden Surname)

Grace A. Fields

19a. Informant's Name/Relationship (Type, Print)

Bernard Joseph Loonam/Brother

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2223 Astor Street, Majorca #6, Orange Park, FL 32073

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Metropolitan Crematory

Date

January 20

20c. Location - City or Town, State

Alexandria, Virginia

21. Signature of Funeral Service Licensee

J. Ken Skiba

22. Name and Address of Facility

Francis J. Collins Funeral Home Inc.
500 University Blvd. W., Silver Spring, MD 2090123a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

Colon Cancer

Approximate
Interval Between
Onset and Death
1 month

a. Due to (or as a consequence of):

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

IF FEMALE:

23b. Was decedent pregnant

in the past 12 months?

1 ☐ Yes 2 ☐ No9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death4 ☐ Pregnant at time of death9 ☐ Unknown3 ☐ Ectopic pregnancy5 ☐ Other (specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an
autopsy
performed?
1 ☐ Yes 2 ☒ No24b. Were autopsy findings available
prior to completion of cause of
death?
1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending
investigation6 ☐ Could not be
determined

28a. Date of Injury

(Month, Day Year)

28b. Time of
Injury

M

28c. Injury at
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Olga Kwon, M.D.

29c. License number

D-30927

29d. Date signed (Month, Day, Year)

January, 20, 2004

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

10313 Georgia Avenue #209, Silver Spring, MD 20902

31. Date filed (Month, Day, Year)

JAN 21 2004

32. Registrar's Signature

Bernard B Sparks

State
Registrar

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

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To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2004 03881

1- For
State
Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Jeanne Sophie Levy				2. Date of Death Month Day Year January 20, 2004		3. Time of Death 10:45 AM	
	4a. Facility Name (If not institution, give street and number) Cedar Creek Associates- Maple Ridge				4b. City, Town, or Location of Death Rockville		4c. County of Death Montgomery	
Funeral Director	5. Social Security Number 053 38 1298		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 92 Yrs.		8. Date of Birth (Month, Day, Year) November 30, 1911	
	9. Birthplace (State or Foreign Country) New York		10a. State Maryland		10b. County Montgomery		10c. City, Town or Location Rockville	
To Be Completed by Funeral Director	10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				10e. Street and Number 15908 Maple Ridge Court		10f. Zip Code 20853	
	10g. Citizen of What Country? United States				11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:	
To Be Completed by Physician/Medical Examiner	13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: Caucasian		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+)	
	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Housekeeper				16b. Kind of Business/Industry Domestic			
To Be Completed by Physician/Medical Examiner	17. Father's Name (First, Middle, Last) Nathan Nelson				18. Mother's Name (First, Middle, Maiden Surname) Etta Wiren			
	19a. Informant's Name/Relationship (Type, Print) James F. Levy - Son				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 28-35th Street Des Moines Iowa 50312			
To Be Completed by Physician/Medical Examiner	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Union Field Cemetery		20c. Location - City or Town, State Ridgewood, New York	
	21. Signature of Funeral Service Licensee Robert E. Evans				22. Name and Address of Facility Jefferson Funeral Chapel 5755 Castlewellan Drive Alexandria, VA 22315			
To Be Completed by Physician/Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) ANOREXIA Dementia				Approximate Interval Between Onset and Death Months Year			
	23b. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last				23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) 9 <input type="checkbox"/> Unknown			
To Be Completed by Physician/Medical Examiner	23d. Date of delivery Month Day Year				23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown			
	24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No			
To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other (Specify) Group Home			
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined				28a. Date of Injury (Month, Day Year) 28b. Time of Injury M 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 28d. Describe how injury occurred 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)			
To Be Completed by Physician/Medical Examiner	29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				29b. Signature and title of certifier Dr. Suresh K. Gupta			
	29c. License number D-32332				29d. Date signed (Month, Day, Year) 01/22/04			
To Be Completed by Physician/Medical Examiner	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr. Suresh K. Gupta 9801 Georgia Ave. Suite 220 Silver Spring, MD 20902 301-681-5922				31. Date filed (Month, Day, Year) JAN 23 2004			
	32. Registrar's Signature Benjamin S. Sparks				33. Date of Death January 20, 2004			

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2004 03882

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Meade Learmouth

2. Date of Death

January 18, 2004

3. Time of Death

10:35 AM

4a. Facility Name (If not institution, give street and number)

Carriage Hill Nursing Home

4b. City, Town, or Location of Death

Bethesda

4c. County of Death

Montgomery

Funeral
Director

5. Social Security Number

391-01-2236

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

92 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
Sept. 4, 1911

9. Birthplace (State or Foreign Country)

Illinois

Usual Residence of Decedent

10a. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Gaithersburg

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

20620 Plum Creek Court

10f. Zip Code

20882

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☒ Yes 2 ☐ No World
If Yes, Give Year or Dates: War II

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: White

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

3

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

Accountant

16b. Kind of Business/Industry

Federal Government

17. Father's Name (First, Middle, Last)

John Joseph Learmouth

18. Mother's Name (First, Middle, Maiden Surname)

Cora Jane McClure

19a. Informant's Name/Relationship (Type, Print)

Louise L. Sullivan/ Niece

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

20620 Plum Creek Court, Gaithersburg, MD 20882

20a. Method of Disposition

1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☒ Other (Specify Entombment)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Parklawn Memorial

Date

Jan. 23,
2004

20c. Location - City or Town, State

Rockville, Maryland

21. Signature of Funeral Service Licensee

M00689

22. Name and Address of Facility

Robert A. Pumphrey Funeral Home/
Rockville, Inc. 300 West Montgomery Avenue,
Rockville, Maryland 20850-2805

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line.

Approximate
Interval Between
Onset and DeathImmediate Cause (Final
disease or condition
resulting in death)a. Multi-infarction Dementia

Due to (or as a consequence of):

b. Parkinson's Disease

Due to (or as a consequence of):

c. _____
Due to (or as a consequence of):d. _____
Due to (or as a consequence of):Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Prostate Cancer

Chronic Obstructive Pulmonary Disease

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending
2 ☐ Accident investigation
3 ☐ Suicide 6 ☐ Could not be
4 ☐ Homicide determined

28a. Date of Injury

(Month, Day, Year)

28b. Time of

Injury

28c. Injury at

Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D35579

29d. Date signed (Month, Day, Year)

January 19, 2004

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Susan J. Miller, M.D. 6844 Tulip Hill Terrace, Bethesda, Maryland 20816

31. Date filed (Month, Day, Year)

JAN 20 2004

32. Registrar's Signature

[Signature]

State
Registrar

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
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once.Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

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Medical Certification: To Be Completed by Physician/Medical Examiner

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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2004 03883

1- For State Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) MIRIAM K. LARKIN				2. Date of Death Month Day Year JANUARY 16, 2004				3. Time of Death 5:00P M	
	4a. Facility Name (If not institution, give street and number) 6111 MONTROSE ROAD #715				4b. City, Town, or Location of Death ROCKVILLE				4c. County of Death MONTGOMERY	
Funeral Director	5. Social Security Number 579-09-8975		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 84 Yrs.		8. Date of Birth (Month, Day, Year) 09/20/1919		9. Birthplace (State or Foreign Country) WASHINGTON, DC	
	Usual Residence of Decedent									
10a. State MARYLAND		10b. County MONTGOMERY		10c. City, Town or Location ROCKVILLE				10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
10e. Street and Number 6111 MONTROSE ROAD #715				10f. Zip Code 20852		10g. Citizen of What Country? U.S.A.				
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No NAVY If Yes, Give Year or Dates: "unknown"		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: WHITE		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 4				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) ACCOUNTANT			16b. Kind of Business/Industry PRIVATE			
17. Father's Name (First, Middle, Last) MORRIS E. KERN					18. Mother's Name (First, Middle, Maiden Surname) ELIZABETH LEAN					
19a. Informant's Name/Relationship (Type, Print) SHARON R. LEVINE/DAUGHTER					19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 14717 DUNLEITH STREET, GAITHERSBURG, MARYLAND 20878					
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) KING DAVID MEMORIAL			Date JAN 18, 2004		20c. Location - City or Town, State FALLS CHURCH, VIRGINIA		
21. Signature of Funeral Service Licensee 			22. Name and Address of Facility EDWARD SAGEL FUNERAL DIRECTION, INC. 1091 ROCKVILLE PIKE, ROCKVILLE, MARYLAND 20852							
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. LUNG CANCER Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last										
Approximate Interval Between Onset and Death 8 MONTHS										
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown			23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <input type="checkbox"/> Unknown				23d. Date of delivery Month Day Year			
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							23e. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown			
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No							
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide			28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred	
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)					28f. Location (Street and Number or Rural Route Number, City or Town, State)					
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.										
29b. Signature and title of certifier 					29c. License number MARYLAND D 51616		29d. Date signed (Month, Day, Year) 01-17-2004			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) NELSON KALIL 18111 Prince Philip Drive #328 Olney, MD 20832										
31. Date filed (Month, Day, Year) JAN 22 2004					32. Registrar's Signature 					

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2004 03884

1- For
State
RegistrarPhysician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

MARILYN MARGARET LANZARONE

2. Date of Death

Month Day Year
JAN. 21, 2004

3. Time of Death

2:40 P M

Funeral
Director

4a. Facility Name (If not institution, give street and number)

MONTGOMERY VILLAGE NURSING HOME

4b. City, Town, or Location of Death

MONTGOMERY VILLAGE

4c. County of Death

MONTGOMERY

5. Social Security Number

473-28-9129

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

74

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
AUG. 4, 1929

9. Birthplace (State or Foreign Country)

MINNESOTA

Usual Residence of Decedent

10a. State

MD.

10b. County

MONTGOMERY

10c. City, Town or Location

MONTGOMERY VILLAGE

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

19301 WATKINS MILL RD.

10f. Zip Code

20886

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

HOUSEWIFE

16b. Kind of Business/Industry

HOME

17. Father's Name (First, Middle, Last)

WILLIAM WINTHEISER

18. Mother's Name (First, Middle, Maiden Surname)

ALICE BORNGESSER

19a. Informant's Name/Relationship (Type, Print)

VICTORIA DOWDY/DAUGHTER

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

12112 SKIP JACK DR., GERMANTOWN, MD. 20874

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

CHAMBERS CREMATORY

Date

1-23-2004

20c. Location - City or Town, State

RIVERDALE, MD.

21. Signature of Funeral Service Licensee

M00091

22. Name and Address of Facility

CHAMBERS FUNERAL HOME & CREMATORIUM, P.A.
5801 CLEVELAND AVE., RIVERDALE, MD. 20737

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Due to (or as a consequence of):

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Approximate Interval Between Onset and Death

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☒ No
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy
4 ☐ Pregnant at time of death 5 ☐ Other (specify)
9 ☐ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural 5 ☐ Pending investigation
2 ☐ Accident 6 ☐ Could not be determined
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number

H005128

29d. Date signed (Month, Day, Year)

1-22-2004

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ANUSHIRAVAN DADGAR, D.O., 9715 MEDICAL CENTER DR., #201, ROCKVILLE, MD. 20850

State
Registrar

31. Date filed (Month, Day, Year)

JAN 23 2004

32. Registrar's Signature

Sparks

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2004 03885

1- For
State
RegistrarPhysician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Lillian A. LaMacchia

2. Date of Death

Month Day Year
JANUARY 11, 2004

3. Time of Death

1:25P. M

Funeral
Director

4a. Facility Name (If not institution, give street and number)

5407 CHRISTIE DRIVE

4b. City, Town, or Location of Death

BETHESDA

4c. County of Death

MONTGOMERY

5. Social Security Number

064-12-8632

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

86

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
Aug. 4, 1917

9. Birthplace (State or Foreign Country)

New York

Usual Residence of Decedent

10a. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Bethesda

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

5407 Christy Dr.

10f. Zip Code

20816

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☒ Never Married 2 ☐ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: White

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4or 5+)

4

16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired)

Division Chief

16b. Kind of Business/Industry

Voice of America

17. Father's Name (First, Middle, Last)

Alex LaMacchia

18. Mother's Name (First, Middle, Maiden Surname)

Carmela Ciccititti

19a. Informant's Name/Relationship (Type, Print)

Neil Costello/ Nephew

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

93 Branford Rd., North Branford, CT 06471

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Mt. Comfort Crematory

Date

Jan. 17, 2004

20c. Location - City or Town, State

Alexandria, Virginia

21. Signature of Funeral Service Licensee

M. L. X. M01296

22. Name and Address of Facility Joseph Gawler's Sons, Inc.

5130 Wisconsin Ave., NW, Washington, DC 20016

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Hypothermia Complicating hypertensive atherosclerotic cardiovascular disease

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

Approximate Interval Between Onset and Death

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☒ No3 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death5 ☐ Other (specify)9 ☐ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Extremity Injuries

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☒ Yes 2 ☐ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☒ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☒ Yes 2 ☐ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☒ Other (Specify) SCENE

27. Manner of Death

1 ☐ Natural 2 ☒ Accident 3 ☐ Suicide 4 ☐ Homicide5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

Found 1-11-04

28b. Time of Injury

Found 1:00 PM

28c. Injury at Work?

1 ☐ Yes 2 ☒ No

28d. Describe how injury occurred

Subject was exposed to cold and fell

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

inside yard

28f. Location (Street and Number or Rural Route Number, City or Town, State)

5407 Christie Drive Bethesda MD

29a. Certifier (Check only one)

1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

M. L. X. M.D.

29c. License number

O.C.M.E.

29d. Date signed (Month, Day, Year)

JANUARY 12, 2004

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

LING LI, MD

111 Penn Street, Baltimore, Maryland 21201

State
Registrar

31. Date filed (Month, Day, Year)

JAN 20 2004

32. Registrar's Signature

B. Sparks

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2004 03886

1- For State Registrar

Physician /Medical Examiner

Funeral Director

1. Decedent's Name (First, Middle, Last) Armando S. Lagman		2. Date of Death Month JANUARY Day 17 Year 2004		3. Time of Death 7:55A. M	
4a. Facility Name (If not institution, give street and number) CIVISTA MEDICAL CENTER		4b. City, Town, or Location of Death La Plata		4c. County of Death CHARLES	
5. Social Security Number 577-76-3906	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 63 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) 03/12/1940
9. Birthplace (State or Foreign Country) Philippines					
Usual Residence of Decedent					
10a. State Maryland	10b. County Charles	10c. City, Town or Location Waldorf		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
10e. Street and Number 5115 Vest Lane		10f. Zip Code 20601		10g. Citizen of What Country? USA	
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:	
14. Race - American Indian, Black, White, etc. Specify: Filipino		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4or 5+) College			
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Bus Boy		16b. Kind of Business/Industry Restaurant Industry			
17. Father's Name (First, Middle, Last) Federico Lagman			18. Mother's Name (First, Middle, Maiden Sumame) Mercedes Seismundo		
19a. Informant's Name/Relationship (Type, Print) Susana Tan Lagman / Wife			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5115 Vest Lane Waldorf, Maryland 20601		
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Resurrection Cemetery		20c. Location - City or Town, State Clinton, Maryland	
21. Signature of Funeral Service Licensee 		22. Name and Address of Facility George P. Kalas Funeral Home P.A. 6160 Oxon Hill Road Oxon Hill, Maryland 20745			
23a-Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Hypertensive atherosclerotic cardiovascular disease Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last					
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Other (specify) <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Unknown		23d. Date of delivery Month Day Year	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.					
23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown					
24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No			
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M	
28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred			
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.					
29b. Signature and title of certifier 		29c. License number O.C.M.E.		29d. Date signed (Month, Day, Year) JANUARY 20, 2004	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) LING LI, M.D. 111 Penn Street, Baltimore, Maryland 21201					
31. Date filed (Month, Day, Year) JAN 21 2004		32. Registrar's Signature 			

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2004 03887

1- For
State
RegistrarPhysician
/Medical
ExaminerFuneral
Director

1. Decedent's Name (First, Middle, Last) GUN SUP LEE		2. Date of Death Month JAN. Day 10, Year 2004		3. Time of Death 8:30 P M	
4a. Facility Name (If not institution, give street and number) 3347 HEWITT AVE. APT. #201		4b. City, Town, or Location of Death SILVER SPRING		4c. County of Death MONTGOMERY	
5. Social Security Number 214-19-9903		6. Sex 1 M 2 F		7. Age (in yrs. last birthday) 69 Yrs.	
8. Date of Birth (Month, Day, Year) FEB 10, 1934		9. Birthplace (State or Foreign Country) SEOUL, KOREA			
Usual Residence of Decedent					
10a. State MD		10b. County MONTGOMERY		10c. City, Town or Location SILVER SPRING	
10d. Inside City Limits 1 Yes 2 No					
10e. Street and Number 3347 HEWITT AVE. APT. #201		10f. Zip Code 20906		10g. Citizen of What Country? USA	
11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Yes 2 No Specify:	
14. Race - American Indian, Black, White, etc. Specify: ASIAN					
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 4		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) SECURITY AGENT		16b. Kind of Business/Industry NATIONAL SECURITY	
17. Father's Name (First, Middle, Last) BYUNG MOK LEE		18. Mother's Name (First, Middle, Maiden Surname) BYOUNG SU O			
19a. Informant's Name/Relationship (Type, Print) JUNE LEE (Son)		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3347 HEWITT AVE. APT. #201 SILVER SPRING, MD 20906			
20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) NO.VA.CREMATORY		20c. Location - City or Town, State 1-12-04 ARLINGTON, VA.	
21. Signature of Funeral Service Licensee 		22. Name and Address of Facility PHILLIP BELL 4902 STAN HAVEN RD. TEMPLE HILLS, MD 20748			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Cancer of the Liver		Approximate Interval Between Onset and Death From 2002			
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last					
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown		23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify)		23d. Date of delivery Month Day Year	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown			
24a. Was an autopsy performed? 1 Yes 2 No		24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No			
25. Was case referred to medical examiner? 1 Yes 2 No		26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify)			
27. Manner of Death 1 Natural 2 Accident 3 Suicide 4 Homicide 5 Pending investigation 6 Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M	
28c. Injury at Work? 1 Yes 2 No		28d. Describe how injury occurred			
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) 2 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.					
29b. Signature and title of certifier 		29c. License number Doo21033		29d. Date signed (Month, Day, Year) January 12, 2004	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr. B.K. Lee 13000 Georgia Ave., Silver Springs, Md. 20906					
31. Date filed (Month, Day, Year) JAN 14 2004		32. Registrar's Signature 			

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2004 03888

1- For
State
Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) BEULAH LEGGETT				2. Date of Death Month 1 Day 19 Year 2004				3. Time of Death 4:05 A^M	
	4a. Facility Name (If not institution, give street and number) HOLY CROSS HOSPITAL				4b. City, Town, or Location of Death SILVER SPRING				4c. County of Death MONTGOMERY	
Funeral Director	5. Social Security Number 237-60-7462		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 62 Yrs.		8. Date of Birth (Month, Day, Year) 5 28 1941		9. Birthplace (State or Foreign Country) NORTH CAROLINA	
	Usual Residence of Decedent									
10a. State MD		10b. County PRINCE GEORGE'S		10c. City, Town or Location LANDOVER				10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
10e. Street and Number 7531 ALLENDALE DRIVE				10f. Zip Code 20785		10g. Citizen of What Country? U.S.A.				
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: BLACK		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 2+ College (1-4or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) FOOD SERVICE			16b. Kind of Business/Industry PRIVATE			
17. Father's Name (First, Middle, Last) LESLIE MCLEAN					18. Mother's Name (First, Middle, Maiden Surname) Annie Bell McCalister					
19a. Informant's Name/Relationship (Type, Print) CHARLES LEGGETT SR./HUSBAND					19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7531 ALLENDALE DRIVE LANDOVER MARYLAND 20785					
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) FT LINCOLN CEMETERY			Date 1-24-2004		20c. Location - City or Town, State BRENTWOOD, MARYLAND		
21. Signature of Funeral Service Licensee K. D. Marshall					22. Name and Address of Facility J.B. JENKINS FUNERAL HOME 7474 LANDOVER ROAD LANDOVER, MARYLAND 20785					
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) G I BLEEDING Due to (or as a consequence of): ACUTE MYOCARDIAL INFARCTION Due to (or as a consequence of): CARDIAC ARREST Due to (or as a consequence of): Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last										Approximate Interval Between Onset and Death
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown			23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Unknown			3 <input type="checkbox"/> Ectopic pregnancy 5 <input type="checkbox"/> Other (specify)		23d. Date of delivery Month Day Year		
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							23a. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown			
							24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined			28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred	
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)					28f. Location (Street and Number or Rural Route Number, City or Town, State)					
29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.										
29b. Signature and title of certifier Chaf n.d					29c. License number 20056063		29d. Date signed (Month, Day, Year) JAN 20, 2004			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) KANWALJIT K. NAGI M.D. 1500 FOREST GLEN ROAD SILVER SPRING, MARYLAND 20910										
31. Date filed (Month, Day, Year) JAN 23 2004					32. Registrar's Signature Becker & Sparte					

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

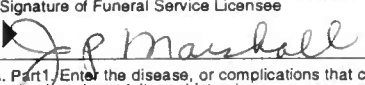


Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2004 03889

1- For State Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Barbara Jean Lindsey				2. Date of Death Month 01 Day 14 Year 04		3. Time of Death 1:12 P M	
	4a. Facility Name (If not institution, give street and number) Surburan Hospital				4b. City, Town, or Location of Death Bethesda		4c. County of Death Montgomery	
Funeral Director	5. Social Security Number 578-56-7728		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 60 Yrs.		8. Date of Birth (Month, Day, Year) 11 21 43	
	9. Birthplace (State or Foreign Country) Washington, D.C.		10a. State MD		10b. County Montgomery		10c. City, Town or Location Bethesda	
10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No								
10e. Street and Number 4521 East West Highway #101								
10f. Zip Code 20814								
10g. Citizen of What Country? USA								
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: Black	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+)			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Property Manager			16b. Kind of Business/Industry Housing Opportunities Commission Montgomery Co.		
17. Father's Name (First, Middle, Last) George D. Lewis, Sr.				18. Mother's Name (First, Middle, Maiden Surname) Mattie A. Edge				
19a. Informant's Name/Relationship (Type, Print) Joseph C. Lindsey Son				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1165 North Shore Drive #22 Reston, VA. 20190				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) Harmony Memorial Park		Date 1-24-04		20c. Location - City or Town, State Landover, MD.	
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility Marshall's Funeral Home 4217 9th. St. N.W. Washington, D.C. 20011				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Anoxic Encephalopathy Due to (or as a consequence of): b. Cardiac Arrest Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last								
23b. IF FEMALE: Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown								
23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <input type="checkbox"/> Unknown								
23d. Date of delivery Month Day Year								
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								
23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown								
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined			28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28d. Describe how injury occurred					
28f. Location (Street and Number or Rural Route Number, City or Town, State)								
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.								
29b. Signature and title of certifier 				29c. License number D37891		29d. Date signed (Month, Day, Year) January 14, 2004		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) A. Rajuansm, MD 121 Congressional Lane #409 Rockville, MD. 20852								
31. Date filed (Month, Day, Year) JAN 23 2004				32. Registrar's Signature 				

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0036

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2004 03890

1- For
State
Registrar

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

JOANIE MAE MYRICK

2. Date of Death

Month Day Year
JAN. 12, 2004

3. Time of Death

1945 M

Funeral
Director

4a. Facility Name (If not institution, give street and number)

Shady Grove Adventist Hospital

4b. City, Town, or Location of Death

Rockville

4c. County of Death

MONTGOMERY

5. Social Security Number

215-44-3689

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

57

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
Mar. 30, 1946

9. Birthplace (State or Foreign Country)

Wash. DC

Usual Residence of Decedent

10a. State

MD

10b. County

Montgomery

10c. City, Town or Location

Derwood

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

7229 Mill Run Drive

10f. Zip Code

20855

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: Black

15. Decedent's Education
(Specify only highest grade completed)Elementary/Secondary (0-12)
12th

College (1-4 or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Housewife

16b. Kind of Business/Industry

Home

17. Father's Name (First, Middle, Last)

John Hall

18. Mother's Name (First, Middle, Maiden Surname)

Fannie Mae Tuell

19a. Informant's Name/Relationship (Type, Print)

John L. Myrick (Husband)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

7229 Mill Run Dr., Derwood, MD 20855

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Arlington Nat'l Cem 1/29/04 Ft. Myer, VA

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

SNOWDEN FUNERAL HOME, P.A.

246 N. Wash. St., Rockville, MD 20850

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.

Acute Arrhythmia

Approximate
Interval Between
Onset and Death
MinutesSequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

- a. Due to (or as a consequence of):
- b. Due to (or as a consequence of):
- c. Due to (or as a consequence of):
- d.

IF FEMALE:

23b. Was decedent pregnant
in the past 12 months?
1 ☐ Yes 2 ☐ No
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown3 ☐ Ectopic pregnancy
5 ☐ Other (specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an
autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings available
prior to completion of cause of
death?1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?
☒ Yes 2 ☐ No

Hospital:

☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

☒ Natural 5 ☐ Pending
investigation
2 ☐ Accident 6 ☐ Could not be
determined
3 ☐ Suicide
4 ☐ Homicide28a. Date of Injury
(Month, Day Year)28b. Time of
Injury28c. Injury at
Work?
1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D51980

29d. Date signed (Month, Day, Year)

Jan. 12, 2004

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Brett Gamma, M.D. 9901 Medical Center Dr., Rockville, MD 20850

State
Registrar

31. Date filed (Month, Day, Year)

JAN 20 2004

32. Registrar's Signature

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permi. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
important: if item 27 is marked other than "natural", or items 23a or 28a-f show
any injury or other traumatic event, the Medical Examiner must be notified at
once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2004 03891

1- For
State
RegistrarPhysician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Ruth Ellen Bell Muse

2. Date of Death

Month Day Year
January 16, 2004

3. Time of Death

2:12 A M

4a. Facility Name (If not institution, give street and number)

Heartland Health Care Center

4b. City, Town, or Location of Death

Hyattsville

4c. County of Death

Prince George's

5. Social Security Number

577-60-5878

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

82 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
March 1, 1921

9. Birthplace (State or Foreign Country)

Washington, DC

Usual Residence of Decedent

10a. State

D.C.

10b. County

N/A

10c. City, Town or Location

Washington

10d. Inside City Limits

☒ Yes 2 ☐ No

10e. Street and Number

5125 Chillum Place, N.E.

10f. Zip Code

20011

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: Black

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Administrative Assistant

16b. Kind of Business/Industry

Federal Government

17. Father's Name (First, Middle, Last)

unavailable

18. Mother's Name (First, Middle, Maiden Surname)

Pauline Turner

19a. Informant's Name/Relationship (Type, Print)

Randolph Muse (husband)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

5125 Chillum Pl. N.E., Washington, D.C. 20011

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Maryland National

Date

1/22/04

20c. Location - City or Town, State

Laurel, MD

21. Signature of Funeral Service Licensee

Andre Thompson

22. Name and Address of Facility

McGuire Funeral Service
7400 Georgia Ave. N.W., Washington, D.C. 2001223a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

a. Arteriosclerotic Cardiovascular Disease

Due to (or as a consequence of):

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate
Interval Between
Onset and Death
years

IF FEMALE:

23b. Was decedent pregnant
in the past 12 months?1 ☐ Yes 2 ☐ No
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy
4 ☐ Pregnant at time of death 5 ☐ Other (specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Dementia

Stage IV Sacral decubitus

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an
autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings available
prior to completion of cause of
death?1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation
6 ☐ Could not be determined28a. Date of Injury
(Month, Day Year)28b. Time of
Injury28c. Injury at
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
and manner stated.

29b. Signature and title of certifier

Paul A. DeVore, M.D.

29c. License number

D01852

29d. Date signed (Month, Day, Year)

January 22, 2004

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Paul A. DeVore, M.D. 4203 Queensbury Road, Hyattsville, MD 20781

31. Date filed (Month, Day, Year)

JAN 23 2004

32. Registrar's Signature

B Sparks

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial/transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification; To Be Completed by Physician/Medical Examiner

State
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2004 03892

1- For
State
Registrar

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Anita Murray

2. Date of Death

January 15, 2004

3. Time of Death

8:30A^M

4a. Facility Name (If not institution, give street and number)

3618 Littledale Rd, #205

4b. City, Town, or Location of Death

Kensington

4c. County of Death

Montgomery

Funeral
Director

5. Social Security Number

048-18-6869

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

96 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
Mar 21, 1907

9. Birthplace (State or Foreign Country)

Mexico

Usual Residence of Decedent

10a. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Kensington

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

3618 Littledale Rd, #205

10f. Zip Code

20895

10g. Citizen of What Country?

USA

11. Marital Status

1 ☒ Never Married 2 ☐ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.Specify:
White15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4or 5+)

5+

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Teacher

16b. Kind of Business/Industry

Education

17. Father's Name (First, Middle, Last)

George C. Murray

18. Mother's Name (First, Middle, Maiden Surname)

Mary Reed Dand

19a. Informant's Name/Relationship (Type, Print)

Nancy Warmington/Personal Rep.

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

M&T Bank, P.O. Box 1596, Baltimore, MD 21203

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Loudon Park Crematory Jan 23, 2004 Baltimore, MD

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

▶ Alan J. Donnell

22. Name and Address of Facility

Hines-Rinaldi Funeral Home
11800 New Hampshire Ave, Silver Spring, MD 2090423a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

Pneumonia

a. Due to (or as a consequence of):

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

Post Hepatic

b. Due to (or as a consequence of):

Chronic Pain

c. Due to (or as a consequence of):

Osteoporosis

d. Due to (or as a consequence of):

Approximate
Interval Between
Onset and Death

IF FEMALE:

23b. Was decedent pregnant
in the past 12 months?
1 ☐ Yes 2 ☒ No
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown3 ☐ Ectopic pregnancy
5 ☐ Other (specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Macular degeneration

Blindness

Osteoporosis

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown24a. Was an
autopsy
performed?
1 ☐ Yes 2 ☒ No24b. Were autopsy findings available
prior to completion of cause of
death?
1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending
investigation
2 ☐ Accident 6 ☐ Could not be
determined
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury

(Month, Day Year)

28b. Time of
Injury28c. Injury at
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)29. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
and manner stated.

29b. Signature and title of certifier

▶ Alan J. Donnell, M.D.

29c. License number

D53691

29d. Date signed (Month, Day, Year)

Jan. 16. 2004

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Alan J. Donnell, 6320 Democracy Blvd, Beltsville, MD 20817.

31. Date filed (Month, Day, Year)

JAN 23 2004

32. Registrar's Signature

▶ [Signature] Sparks

State
Registrar

Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show
any injury or other traumatic event, the Medical Examiner must be notified at
once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2004 03893

Certificate of Death

Reg. No.

1- For
State
RegistrarPhysician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

William P. Mullin

2. Date of Death

January 16, 2004

3. Time of Death

2:00 P M

Funeral
Director

4a. Facility Name (If not institution, give street and number)

Casey House

4b. City, Town, or Location of Death

Rockville

4c. County of Death

Montgomery

5. Social Security Number

577-09-7416

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

85 Yrs.

If Under 1 Year
Months DaysIf Under 24 Hrs.
Hours Min.8. Date of Birth
(Month, Day, Year)

Dec. 18, 1918

9. Birthplace (State or Foreign
Country)

Virginia

Usual Residence of Decedent

10a. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Silver Spring

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

3919 Joliet St.

10f. Zip Code

20906

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced12. Was Decedent Ever in U.S.
Armed Forces?1 ☐ Yes 2 ☐ No
If Yes, Give
Year or Dates: 1942-
194513. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: White

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4or 5+)

12th

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Manager

16b. Kind of Business/Industry

Grocery

17. Father's Name (First, Middle, Last)

Francis Isaac Mullin

18. Mother's Name (First, Middle, Maiden Surname)

Mabel Warren

19a. Informant's Name/Relationship (Type, Print)

Lillian G. Mullin- Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

3919 Joliet St. Silver Spring, MD 20906

20a. Method of Disposition

1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Parklawn Mem. Park

Date

01/19/2004

20c. Location - City or Town, State

Rockville, MD

21. Signature of Funeral Service Licensee

Dennis E. Wil

22. Name and Address of Facility

Hines-Rinaldi Funeral Home
11800 New Hampshire Ave. Silver Spring, MD 2090423a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

Pulmonary Fibrosis

Due to (or as a consequence of):

CHF

Due to (or as a consequence of):

Due to (or as a consequence of):

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) LastApproximate
Interval Between
Onset and Death

IF FEMALE:

23b. Was decedent pregnant
in the past 12 months?
1 ☐ Yes 2 ☐ No
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy
4 ☐ Pregnant at time of death 5 ☐ Other (specify)
9 ☐ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown24a. Was an
autopsy
performed?
1 ☐ Yes 2 ☒ No24b. Were autopsy findings available
prior to completion of cause of
death?
1 ☐ Yes 2 ☒ No25. Was case referred to medical
examiner?
1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☒ Other (Specify)

Hospice

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation
6 ☐ Could not be determined28a. Date of Injury
(Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

D. Karakunnel

29c. License number

D60582

29d. Date signed (Month, Day, Year)

January 17, 2004

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Loyson Karakunnel, M.D. 6001 Muncaster Mill Rd. Rockville, MD 20855

State
Registrar

31. Date filed (Month, Day, Year)

JAN 20 2004

32. Registrar's Signature

Dennis E. Wil

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 23e-f show
any injury or other traumatic event, the Medical Examiner must be notified at
once.To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit
permit.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2004 03894

1- For
State
RegistrarPhysician
/Medical
ExaminerFuneral
Director

1. Decedent's Name (First, Middle, Last) SARA RUTH MODELL				2. Date of Death Month Day Year JANUARY 11, 2004		3. Time of Death 3:20P M	
4a. Facility Name (If not institution, give street and number) HOLY CROSS REHAB & NURSING CENTER				4b. City, Town, or Location of Death BURTONSVILLE		4c. County of Death MONTGOMERY	
5. Social Security Number 040-32-7712		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 91 Yrs.		8. Date of Birth (Month, Day, Year) DEC. 14, 1912	
9. Birthplace (State or Foreign Country) NEW YORK		10a. State MARYLAND		10b. County MONTGOMERY		10c. City, Town or Location BETHESDA	
10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		10e. Street and Number 4925 BATTERY LANE		10f. Zip Code 20814		10g. Citizen of What Country? UNITED STATES OF AMERICA	
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: WHITE	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 11 College (1-4or 5+) BOOKKEEPER		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)		16b. Kind of Business/Industry MCCROY'S DEPARTMENT STORE			
17. Father's Name (First, Middle, Last) MORRIS FINGER				18. Mother's Name (First, Middle, Maiden Surname) ANNA MIRSKY			
19a. Informant's Name/Relationship (Type, Print) ROBERT L. MODELL - SON				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10 WHITEHALL ROAD, MONROE TOWNSHIP, NEW JERSEY 08831			
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) NATIONAL CREMATORY		20c. Date 01/14/04		20d. Location - City or Town, State FALLS CHURCH, VIRGINIA	
21. Signature of Funeral Service Licensee Donald C. Stottmeyer				22. Name and Address of Facility DANZANSKY GOLDBERG MEMORIAL CHAPEL, INC. 1170 ROCKVILLE PIKE ROCKVILLE, MD 20852			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. DEMENTIA Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last				Approximate Interval Between Onset and Death 2 YEARS			
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Unknown		23d. Date of delivery Month Day Year			
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. HYPERTENSION				23a. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown			
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				29b. Signature and title of certifier Dr. Nathan M.D.		29c. License number 00053615	
29d. Date signed (Month, Day, Year) January, 12th, 2004		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ARUNA S. NATHAN MD		31. Date filed (Month, Day, Year) JAN 20 2004		32. Registrar's Signature Sparks	

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

2

State
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Register AMEND #26 per MDL/29/04 RMA, McCo
AMEND #14 per INE, 1/29/04, BWA, McCo

Certificate of Death

Reg. No.

2004 03895

Physician
/Medical
Examiner

Funeral
Director

1. Decedent's Name (First, Middle, Last) Yasmin K. Mithani		2. Date of Death Month January Day 14 Year 2004		3. Time of Death 10:10P. M	
4a. Facility Name (If not institution, give street and number) 1406 Waterford Drive		4b. City, Town, or Location of Death Bel Air		4c. County of Death Harford	
5. Social Security Number 568-61-0598		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 51 Yrs.	
8. Date of Birth (Month, Day, Year) May 18, 1952		9. Birthplace (State or Foreign Country) Bombay, India			
Usual Residence of Decedent					
10a. State Maryland		10b. County Harford		10c. City, Town or Location Bel Air	
10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No					
10e. Street and Number 1406 Waterford Drive		10f. Zip Code 21015		10g. Citizen of What Country? United States	
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:	
14. Race - American Indian, Black, White, etc. Specify: Asian Indian					
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (9-12) 12 College (1-4 or 5+) 5		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Office Manager		16b. Kind of Business/Industry Healthcare	
17. Father's Name (First, Middle, Last) Hasanali Sani		18. Mother's Name (First, Middle, Maiden Surname) Fatima Ramji			
19a. Informant's Name/Relationship (Type, Print) Kamrudin Mithani -Husband		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1406 Waterford Drive Bel Air, Maryland 21015			
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) George Washington Cem.		20c. Location - City or Town, State Adelphi, Maryland	
21. Signature of Funeral Service Licensee 		22. Name and Address of Facility Donald V. Borgwardt Funeral Home, P.A. 4400 Powder Mill Rd. Beltsville, Maryland 20705			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.					
Immediate Cause (Final disease or condition resulting in death)					
a. Liver Failure					
Due to (or as a consequence of):					
b. Metastatic Adenocarcinoma of unknown primary					
Due to (or as a consequence of):					
c.					
Due to (or as a consequence of):					
d.					
Approximate Interval Between Onset and Death 1 week					
Approximate Interval Between Onset and Death 5 months					
IF FEMALE:					
23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 9 <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 4 <input type="checkbox"/> Pregnant at time of death 9 <input type="checkbox"/> Unknown		23d. Date of delivery Month Day Year	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.					
23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown					
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No					
24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No					
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M	
		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred	
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)	
29a. Certifier (Check only one) 2 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.					
29b. Signature and title of certifier 		29c. License number D0060111		29d. Date signed (Month, Day, Year) January 16, 2004	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Andrew J. Armstrong, M.D. 401 North Broadway Baltimore, Maryland 21231					
31. Date filed (Month, Day, Year) JAN 21 2004		32. Registrar's Signature 			

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 23e-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene
Certificate of Death

Reg. No.

2004 03896

1- For
State
RegistrarPhysician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

ROSE MILLER

2. Date of Death

Month Day Year
JANUARY 14, 2004

3. Time of Death

2210 M

Funeral
Director

4a. Facility Name (If not institution, give street and number)

SUBURBAN HOSPITAL

4b. City, Town, or Location of Death

BETHESDA

4c. County of Death

MONTGOMERY

5. Social Security Number

164-14-0552

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

84 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
MAY 18, 1919

9. Birthplace (State or Foreign Country)

PENNSYLVANIA

Usual Residence of Decedent

10a. State

MARYLAND

10b. County

MONTGOMERY

10c. City, Town or Location

BETHESDA

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

5225 POOKS HILL ROAD APT. 1129N

10f. Zip Code

20814

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: WHITE

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

11

College (1-4or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

SALES CLERK

16b. Kind of Business/Industry

RETAIL

17. Father's Name (First, Middle, Last)

DAVID OLENSKY

18. Mother's Name (First, Middle, Maiden Surname)

LIZZIE ROSENBERG

19a. Informant's Name/Relationship (Type, Print)

BOB P. MILLER/SOON

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

8905 POTOMAC STATION LANE, POTOMAC, MD 20854

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

PARKLAWN MEM. PARK

Date

01/18/2004

20c. Location - City or Town, State

ROCKVILLE, MARYLAND

21. Signature of Funeral Service Licensee

Amanda Ludewig

22. Name and Address of Facility

EDWARD SAGEL FUNERAL DIRECTION, INC.
1091 ROCKVILLE PIKE, ROCKVILLE, MD 2085223a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

a. VENTRICULAR FIBRILLATION

Due to (or as a consequence of):

Approximate
Interval Between
Onset and Death

2 HOURS

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

b. ACUTE MYOCARDIAL ISCHEMIA

Due to (or as a consequence of):

3 HOURS

c. ACUTE CORONARY OCCLUSION

Due to (or as a consequence of):

3 HOURS

IF FEMALE:

23b. Was decedent pregnant
in the past 12 months?1 ☐ Yes 2 ☒ No
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown3 ☐ Ectopic pregnancy
5 ☐ Other (specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an
autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings available
prior to completion of cause of
death?1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☒ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending
2 ☐ Accident investigation
3 ☐ Suicide 6 ☐ Could not be
4 ☐ Homicide determined

28a. Date of Injury

(Month, Day Year)

28b. Time of
Injury

M

28c. Injury at
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
and manner stated.

29b. Signature and title of certifier

John Galotto

29c. License number

D11921

29d. Date signed (Month, Day, Year)

JANUARY 15, 2004

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

JOHN GALOTTO, M.D., 8600 OLD GEROGETOWN ROAD, BETHESDA, MD 20814

31. Date filed (Month, Day, Year)

JAN 22 2004

32. Registrar's Signature

[Signature]

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show
any injury or other traumatic event, the Medical Examiner must be notified at
once.Physician
/Medical
ExaminerTo the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

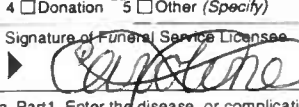
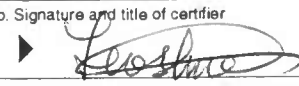

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2004 03897

1- For State Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) MICHAEL O. MILLER				2. Date of Death Month: JAN 15, Day: 2004 Year: 2004		3. Time of Death 13:28 M	
	4a. Facility Name (If not institution, give street and number) SHADY GROVE HOSPITAL			4b. City, Town, or Location of Death ROCKVILLE		4c. County of Death MONTGOMERY		
Funeral Director	5. Social Security Number 033-26-9044		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 65 Yrs.		8. Date of Birth (Month, Day, Year) 3/11/1938	
	9. Birthplace (State or Foreign Country) MASS.		10a. State MARYLAND		10b. County MONTGOMERY		10c. City, Town or Location ROCKVILLE	
To Be Completed by Funeral Director	10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No			10e. Street and Number 4 DON MILLS COURT			10f. Zip Code 20850	
	10g. Citizen of What Country? U.S.A.			11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:	
	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: WHITE			15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 5+ College (1-4or 5+)	
	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) JUDGE			16b. Kind of Business/Industry FEDERAL GOVERNMENT			17. Father's Name (First, Middle, Last) MAX MILLER	
	18. Mother's Name (First, Middle, Maiden Surname) MOLIE KRUGER			19a. Informant's Name/Relationship (Type, Print) CAROL MILLER/WIFE			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4 DON MILLS COURT, ROCKVILLE, MARYLAND 20850	
	20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) METROPOLITAN CREMATORY			20c. Date JAN 18, 2004	
	20d. Location - City or Town, State ALEXANDRIA, VIRGINIA			21. Signature of Funeral Service Licensee 			22. Name and Address of Facility EDWARD SAGEL FUNERAL DIRECTION, INC. 1091 ROCKVILLE PIKE, ROCKVILLE, MARYLAND 20852	
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. hemorrhage stroke Due to (or as a consequence of):			Approximate Interval Between Onset and Death 1 day			23b. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Other (specify)	
	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d.			23c. Date of delivery Month: _____ Day: _____ Year: _____			23d. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown			23c. Date of delivery Month: _____ Day: _____ Year: _____			23d. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								
23a. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown								
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No								
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								
26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> OOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)								
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide								
28a. Date of Injury (Month, Day Year) _____ 28b. Time of Injury _____ M _____ 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								
28d. Describe how injury occurred _____ 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) _____ 28f. Location (Street and Number or Rural Route Number, City or Town, State) _____								
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.								
29b. Signature and title of certifier  M.D.								
29c. License number D60557								
29d. Date signed (Month, Day, Year) January 15, 2004								
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DR. LEO SHUE, SHADY GROVE ADVENTIST HOSPITAL, 9901 MEDICAL CENTER WAY, ROCKVILLE, MD 20850								
31. Date filed (Month, Day, Year) JAN 22 2004								
32. Registrar's Signature 								

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

510

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar AMEND#1 per MD1/29/04, BMW, McCo

Certificate of Death

Reg. No.

2004 03898

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last) Louise Pledger Meyer
Ava Louise Meyer
2. Date of Death Month January Day 15 Year 2004 3. Time of Death 6:30 A.M.

Funeral
Director

4a. Facility Name (If not institution, give street and number) Wilson Health Care Center 4b. City, Town, or Location of Death Gaithersburg 4c. County of Death Montgomery
5. Social Security Number 217-36-9799 6. Sex ☐ M ☒ F 7. Age (In yrs. last birthday) 92 Yrs. 8. Date of Birth (Month, Day, Year) Aug. 11, 1911 9. Birthplace (State or Foreign Country) North Carolina

Usual Residence of Decedent
10a. State Maryland 10b. County Montgomery 10c. City, Town or Location Gaithersburg 10d. Inside City Limits ☒ Yes ☐ No
10e. Street and Number 301 Russell Avenue 10f. Zip Code 20877 10g. Citizen of What Country? United States

11. Marital Status ☐ Never Married ☐ Married ☒ Widowed ☐ Divorced 12. Was Decedent Ever in U.S. Armed Forces? ☐ Yes ☒ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) ☐ Yes ☒ No Specify: 14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4or 5+) Secretary 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) School 16b. Kind of Business/Industry

17. Father's Name (First, Middle, Last) Charles Edward Pledger 18. Mother's Name (First, Middle, Maiden Surname) Ava Harrison

19a. Informant's Name/Relationship (Type, Print) Charles F. Meyer/Son 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) P.O. Box 304, Maugansville, Maryland 21767

20a. Method of Disposition ☐ Burial ☒ Cremation ☐ Removal from State ☐ Donation ☐ Other (Specify) 20b. Place of Disposition (Name of cemetery, crematory or other place) Metropolitan Crematory Date 1/15/2004 20c. Location - City or Town, State Alexandria, Virginia

21. Signature of Funeral Service Licensee [Signature] 22. Name and Address of Facility DeVol Funeral Home
10 East Deer Park Dr., Gaithersburg, MD. 20877

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) congestive heart failure Due to (or as a consequence of): 2 days
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? ☐ Yes ☒ No ☐ Unknown 23c. If yes, outcome of pregnancy ☐ Live birth ☐ Fetal death ☐ Ectopic pregnancy ☐ Pregnant at time of death ☐ Other (specify) ☐ Unknown 23d. Date of delivery Month January Day 15 Year 2004

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Hypertension Seizure Disorder
Alzheimer's dementia
Peripheral vascular disease 23e. Did tobacco use contribute to the cause of death? ☐ Yes ☒ No ☐ Probably ☐ Unknown 24a. Was an autopsy performed? ☐ Yes ☒ No 24b. Were autopsy findings available prior to completion of cause of death? ☐ Yes ☒ No

25. Was case referred to medical examiner? ☐ Yes ☒ No 26. Place of Death (Check only one) Hospital: ☐ Inpatient ☐ ER/Outpatient ☐ DOA Other: ☒ Nursing Home ☐ Residence ☐ Other (Specify) 27. Manner of Death ☒ Natural ☐ Pending investigation ☐ Accident ☐ Could not be determined ☐ Suicide ☐ Homicide 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury M 28c. Injury at Work? ☐ Yes ☒ No 28d. Describe how injury occurred 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier [Signature] 29c. License number D 04115 29d. Date signed (Month, Day, Year) January 15, 2004

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) H. Robert Birschbach, M.D., 201 Russell Avenue, Gaithersburg, MD. 20877

31. Date filed (Month, Day, Year) JAN 20 2004 32. Registrar's Signature [Signature]

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2004 03899

1- For State Registrar

Physician /Medical Examiner

Funeral Director

1. Decedent's Name (First, Middle, Last) George C. Mergner, Jr.		2. Date of Death Month January Day 18 Year 2004		3. Time of Death 1:00 P M	
4a. Facility Name (If not institution, give street and number) Montgomery Hospice Casey House		4b. City, Town, or Location of Death Rockville		4c. County of Death Montgomery	
5. Social Security Number 187-05-7897	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 83 Yrs.	8. Date of Birth (Month, Day, Year) March 11, 1920		9. Birthplace (State or Foreign Country) Pennsylvania
Usual Residence of Decedent					
10a. State Maryland	10b. County Montgomery	10c. City, Town or Location Silver Spring		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
10e. Street and Number 10801 Margate Road		10f. Zip Code 20901		10g. Citizen of What Country? United States	
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: WWII		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:	
14. Race - American Indian, Black, White, etc. Specify: White					
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <input type="checkbox"/> College (1-4 or 5+) <input checked="" type="checkbox"/> 5		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Electrical Engineer		16b. Kind of Business/Industry Manufacturing	
17. Father's Name (First, Middle, Last) George C. Mergner, Sr.		18. Mother's Name (First, Middle, Maiden Surname) Anna Klubal			
19a. Informant's Name/Relationship (Type, Print) Lee C. Mergner/Son		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10801 Margate Road, Silver Spring, Maryland 20901			
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Hillside Cemetery		20c. Location - City or Town, State Roslyn, Pennsylvania	
21. Signature of Funeral Service Licensee William A. Pumphrey M01173		22. Name and Address of Facility Robert A. Pumphrey Funeral Home, Rockville, Inc., 300 W. Montgomery Avenue, Rockville, Maryland 20850			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Parkinson's Disease					
23b. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Atrial Fibrillation Dementia					
23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <input type="checkbox"/> Unknown					
23d. Date of delivery Month Day Year					
23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown					
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) Hospice					
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide					
28a. Date of Injury (Month, Day Year)					
28b. Time of Injury M					
28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
28d. Describe how injury occurred					
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)					
28f. Location (Street and Number or Rural Route Number, City or Town, State)					
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.					
29b. Signature and title of certifier J. Karakunnel					
29c. License number D60582					
29d. Date signed (Month, Day, Year) January 19, 2004					
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Joyson Karakunnel, M.D. 6001 Muncaster Mill Road, Rockville, Maryland 20855					
31. Date filed (Month, Day, Year) JAN 22 2004					
32. Registrar's Signature S Sparks					

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

George Mergner

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial/transit

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2004 03900

1- For
State
RegistrarPhysician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

William Patrick McGuire, Jr.

2. Date of Death
Month Day Year

01 21 04/105/ M

3. Time of Death

4a. Facility Name (If not institution, give street and number)

Washington Adventist Hospital

4b. City, Town, or Location of Death

Takoma Park

4c. County of Death

Montgomery

Funeral
Director

5. Social Security Number

217-84-2506

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

44 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth (Month, Day, Year)

Dec. 29, 1959

9. Birthplace (State or Foreign Country)

Virginia

Usual Residence of Decedent

10a. State

Maryland

10b. County

Prince George's

10c. City, Town or Location

Laurel

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

24 South Paula Street

10f. Zip Code

20707

10g. Citizen of What Country?

USA

11. Marital Status

1 ☒ Never Married 2 ☐ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: White

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working
life. DO NOT use retired)

Supervisor

16b. Kind of Business/Industry

Plumbing

17. Father's Name (First, Middle, Last)

William Patrick McGuire

18. Mother's Name (First, Middle, Maiden Surname)

Lucy Marie Corbin

19a. Informant's Name/Relationship (Type, Print)

Lucy Marie King/ Mother

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

9250 Edwards Way, Adelphi, MD 20783

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)Gate of Heaven
Cemetery

Date

January 26
2004

20c. Location - City or Town, State

Silver Spring, Maryland

21. Signature of Funeral Service Licensee

[Signature]

22. Name and Address of Facility

Francis J. Collins Funeral Home Inc.
500 University Blvd. W., Silver Spring, MD 2090123a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

a. Respiratory failure

Due to (or as a consequence of):

b. Pneumonia

Due to (or as a consequence of):

c. Sleep apnea

Due to (or as a consequence of):

d.

Approximate
Interval Between
Onset and DeathSequentially list conditions,
if any, leading to immediate
cause. Enter underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

IF FEMALE:

23b. Was decedent pregnant
in the past 12 months?1 ☐ Yes 2 ☒ No
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy
4 ☐ Pregnant at time of death 5 ☐ Other (specify)
9 ☐ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Liver failure from alcoholic hepatitis
Renal failure
Encephalopathy

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☒ Unknown24a. Was an
autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings available
prior to completion of cause of
death?1 ☐ Yes 2 ☒ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

26. Place of Death (Check only one)

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation
6 ☐ Could not be determined28a. Date of Injury
(Month, Day, Year)28b. Time of
Injury28c. Injury at
Work?1 ☐ Yes 2 ☒ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Deanna White MD

29c. License number

60953

29d. Date signed (Month, Day, Year)

1/21/04

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Deanna White M.D. 7600 Carroll Avenue, Takoma Park, MD 20912

31. Date filed (Month, Day, Year)

JAN 23 2004

32. Registrar's Signature

[Signature]

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or item 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.Physician
/Medical
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2004 03901

1- For
State
RegistrarPhysician
/Medical
ExaminerFuneral
Director

1. Decedent's Name (First, Middle, Last)

MUKUT VEHARI MATHUR

2. Date of Death
Month Day Year
JAN. 21, 20043. Time of Death
6:15 AM

4a. Facility Name (If not institution, give street and number)

WASHINGTON ADVENTIST HOSPITAL

4b. City, Town, or Location of Death

TAKOMA PARK, MD

4c. County of Death

MONTGOMERY

5. Social Security Number

231-89-2081

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

88 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

JAN. 1, 1916

9. Birthplace (State or Foreign Country)

INDIA

Usual Residence of Decedent

10a. State

VA

10b. County

FAIRFAX

10c. City, Town or Location

BURKE

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

9913 MANET ROAD

10f. Zip Code

22015

10g. Citizen of What Country?

INDIA

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced12. Was Decedent Ever in U.S.
Armed Forces?1 ☐ Yes 2 ☒ No
If Yes, Give
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No.
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.Specify:
ASIAN
INDIAN15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

5+

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

PROFESSOR

16b. Kind of Business/Industry

EDUCATION

17. Father's Name (First, Middle, Last)

SHYAM BEHARI MATHUR

18. Mother's Name (First, Middle, Maiden Surname)

RAJ RANI MATHUR

19a. Informant's Name/Relationship (Type, Print)

DINESH KUMAR-SON-IN-LAW

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

10209 LAWNMARKET CT., ELLICOTT CITY, MD 21042

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

NORTHERN VA CREMATORY

Date

01/23/04

20c. Location - City or Town, State

ARLINGTON, VA

21. Signature of Funeral Service Licensee

Mary Holden 00412

22. Name and Address of Facility

ARLINGTON FUNERAL HOME

3901 N. FAIRFAX DR., ARLINGTON, VA 22203

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)a. Inanition
Due to (or as a consequence of):Approximate
Interval Between
Onset and Death

Unknown

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

IF FEMALE:

23b. Was decedent pregnant
in the past 12 months?
1 ☐ Yes 2 ☐ No
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown3 ☐ Ectopic pregnancy
5 ☐ Other (Specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Hypertensive Cardiovascular disease

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an
autopsy
performed?
1 ☐ Yes 2 ☒ No24b. Were autopsy findings available
prior to completion of cause of
death?
1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?
1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending
investigation
2 ☐ Accident 6 ☐ Could not be
determined
3 ☐ Suicide 4 ☐ Homicide28a. Date of Injury
(Month, Day Year)28b. Time of
Injury28c. Injury at
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

M Khan MD

29c. License number

D18895

29d. Date signed (Month, Day, Year)

January 21, 2004

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MOBARAK KARIM, 7610 CARROLL AVE, TAKOMA PARK, MD 20912

31. Date filed (Month, Day, Year)

JAN 23 2004

32. Registrar's Signature

Benjamin Sparks

State
Registrar

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show
any injury or other traumatic event, a Medical Examiner must be notified at
once.Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.


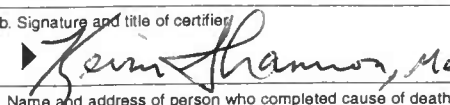

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2004 03902

1- For
State
Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) MARIA De LaPAZ MARTINEZ				2. Date of Death Month JAN. Day 21, Year 2004		3. Time of Death 10:30 A^M		
	4a. Facility Name (If not institution, give street and number) 2812 DENLEY PL.				4b. City, Town, or Location of Death SILVER SPRING		4c. County of Death MONTGOMERY		
Funeral Director	5. Social Security Number 217-45-8033		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 70 Yrs.		8. Date of Birth (Month, Day, Year) JAN. 7, 1934		
	9. Birthplace (State or Foreign Country) EL SALVADOR		10a. State MD.		10b. County MONTGOMERY		10c. City, Town or Location SILVER SPRING		
Usual Residence of Decedent		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		10e. Street and Number 2812 DENLEY PL.		10f. Zip Code 20906		10g. Citizen of What Country? EL SALVADOR	
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No Specify: EL SALVADORIAN		14. Race - American Indian, Black, White, etc. Specify: WHITE			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 1 College (1-4or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) HOMEMAKER		16b. Kind of Business/Industry HOME		17. Father's Name (First, Middle, Last) VICENTE MELENDES		18. Mother's Name (First, Middle, Maiden Surname) CLEOTILDE MEDRANO	
19a. Informant's Name/Relationship (Type, Print) JOSE MARTINEZ/SON		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2812 DENLEY PL., SILVER SPRING, MD. 20906		20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) GATE OF HEAVEN CEM.		20c. Location - City or Town, State 1-26-2004 SILVER SPRING, MD.	
21. Signature of Funeral Service Licensee  M00091		22. Name and Address of Facility CHAMBERS FUNERAL HOME & CREMATORIUM, P.A. 5801 CLEVELAND AVE., RIVERDALE, MD. 20737		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. NON-SMALL CELL LUNG CANCER Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d.		Approximate Interval Between Onset and Death 7 MONTHS			
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <input type="checkbox"/> Unknown		23d. Date of delivery Month Day Year		23e. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No		25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)	
28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)	
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier  KEVIN SHANNON, M.D.		29c. License number D53829		29d. Date signed (Month, Day, Year) JAN. 21, 2004		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) KEVIN SHANNON, M.D. 7525 GREENWAY CENTER DR.#205, GREENBELT, MD. 20770	
31. Date filed (Month, Day, Year) JAN 22 2004		32. Registrar's Signature 		State Registrar					

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2004 03903

Certificate of Death

Reg. No.

1- For
State
Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) DELOISE MARR				2. Date of Death Month Day Year JAN. 17, 2004		3. Time of Death 3:45A M		
	4a. Facility Name (If not institution, give street and number) 102 Ritchie Avenue				4b. City, Town, or Location of Death Silver Spring		4c. County of Death Montgomery		
Funeral Director	5. Social Security Number 220-40-6888		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 69 Yrs.		8. Date of Birth (Month, Day, Year) May 21, 1934		
	9. Birthplace (State or Foreign Country) Maryland		10a. State MD		10b. County Montgomery		10c. City, Town or Location Silver Spring		
Usual Residence of Decedent		10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		10e. Street and Number 102 Ritchie Avenue		10f. Zip Code 20910		10g. Citizen of What Country? U.S.A.	
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: Black			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 11th College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Housewife		16b. Kind of Business/Industry Home		17. Father's Name (First, Middle, Last) Lee A. Jordon		18. Mother's Name (First, Middle, Maiden Surname) Helen Warren	
19a. Informant's Name/Relationship (Type, Print) James W. Marr (Husband)				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 102 Ritchie Ave., Silver Spring, MD 20910					
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Ash Memorial Cem		Date 1/24/04		20c. Location - City or Town, State Sandy Spring, MD			
21. Signature of Funeral Service Licensee 		22. Name and Address of Facility Snowden Funeral Home, PA		22. Name and Address of Facility 246 N Washington St Rockville, MD 20850		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Cardiopulmonary Arrest		Approximate Interval Between Onset and Death	
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Cardiopulmonary Arrest		23b. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Brain Metastasis		23c. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown		23d. Date of delivery Month Day Year			
23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) 9 <input type="checkbox"/> Unknown		23d. Date of delivery Month Day Year		23e. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		23f. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M	
28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier 		29c. License number 56147		29d. Date signed (Month, Day, Year) 1/20/04			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Nasreen Kango, M.D. 7610 Carroll Ave., #205, Takome Park, MD 20912		31. Date filed (Month, Day, Year) JAN 22 2004		32. Registrar's Signature 					

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

1- For State Registrar

2004 03904

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Physician /Medical Examiner	Funeral Director	To Be Completed by Funeral Director	1. Decedent's Name (First, Middle, Last) Vincent A. Mariner	2. Date of Death Month January Day 19 Year 2004	3. Time of Death 5:40 a M
			4a. Facility Name (If not institution, give street and number) Holy Cross Hospital	4b. City, Town, or Location of Death Silver Spring	4c. County of Death Montgomery
			5. Social Security Number 577-30-5638	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 77 Yrs.
			8. Date of Birth (Month, Day, Year) Dec. 18, 1926		9. Birthplace (State or Foreign Country) Washington, DC
			Usual Residence of Decedent		
			10a. State Maryland	10b. County Montgomery	10c. City, Town or Location Silver Spring
			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
			10e. Street and Number 3126 Gracefield Road, Berkshire Gardens #221		10f. Zip Code 20904
			10g. Citizen of What Country? USA		
			11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: WWII
			13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White
			15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Systems Engineer
			16b. Kind of Business/Industry U.S. Government		
			17. Father's Name (First, Middle, Last) Robert Lee Mariner		18. Mother's Name (First, Middle, Maiden Surname) Ester Catherine Kaufman
			19a. Informant's Name/Relationship (Type, Print) Virginia W. Mariner/ Wife		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3126 Gracefield Rd., Berkshire Gardens #221, Silver Spring, MD 20904
			20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Metropolitan Crematory
			20c. Location - City or Town, State Alexandria, Virginia		
			21. Signature of Funeral Service Licensee 		22. Name and Address of Facility Francis J. Collins Funeral Home Inc. 500 University Blvd. W., Silver Spring, MD 20901
			23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Acute Myocardial Infarction Due to (or as a consequence of): Dilated Cardiomyopathy Due to (or as a consequence of): Multi-Organ Failure Due to (or as a consequence of):		
			Approximate Interval Between Onset and Death Days Years Days		
			IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		
			23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <input type="checkbox"/> Unknown		
			23d. Date of delivery Month Day Year		
			Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		
			23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		
			24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
			24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
			25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
			26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		
			27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		
			28a. Date of Injury (Month, Day Year)		
			28b. Time of Injury M		
			28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
			28d. Describe how injury occurred		
			28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		
			28f. Location (Street and Number or Rural Route Number, City or Town, State)		
			29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		
			29b. Signature and title of certifier A. Nawa		
			29c. License number D50987		
			29d. Date signed (Month, Day, Year) 1-19-04		
			30. Name and address of person who completed cause of death (Item 23a) (Type, Print) AHMED NAWA NO PO Box 83819 Gaithersburg MD 20883		
			31. Date filed (Month, Day, Year) JAN 21 2004		
			32. Registrar's Signature 		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2004 03905

Certificate of Death

Reg. No.

1- For
State
RegistrarPhysician
/Medical
ExaminerFuneral
Director

1. Decedent's Name (First, Middle, Last)

Virginia Ann Magruder

2. Date of Death

January 16, 2004

3. Time of Death

8:20 AM

4a. Facility Name (If not institution, give street and number)

Suburban Hospital

4b. City, Town, or Location of Death

Bethesda

4c. County of Death

Montgomery

5. Social Security Number

216-40-8051

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

61 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

July 28, 1942

9. Birthplace (State or Foreign Country)

Washington, D.C.

Usual Residence of Decedent

10a. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Bethesda

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

5305 King Charles Way

10f. Zip Code

20814

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: White

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

5+

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Procurement

16b. Kind of Business/Industry

Federal Government

17. Father's Name (First, Middle, Last)

Hoburg Lee

18. Mother's Name (First, Middle, Maiden Surname)

Frances Reed

19a. Informant's Name/Relationship (Type, Print)

Philip Garvey /Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

5523 Wicomico Drive, New Market, Maryland 21774

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Gate of Heaven Cemetery

Date

January 23,
2004

20c. Location - City or Town, State

Silver Spring, Maryland

21. Signature of Funeral Service Licensee

M01305

22. Name and Address of Facility

Robert A. Pumphrey Funeral Home/Bethesda-Chevy Chase, Inc.
7557 Wisconsin Avenue, Bethesda, Maryland 20814-350123a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

a. Staphylococcal Sepsis

Due to (or as a consequence of):

b. Severe Steroid Dependent

Due to (or as a consequence of):

c. Chronic Obstructive Airway Disease

Due to (or as a consequence of):

d.

Approximate
Interval Between
Onset and Death

IF FEMALE:

23b. Was decedent pregnant
in the past 12 months?1 ☐ Yes 2 ☒ No
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown3 ☐ Ectopic pregnancy5 ☐ Other (specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Hypertension, Anxiety-Depression

23a. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown24a. Was an
autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings available
prior to completion of cause of
death?1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending
investigation
2 ☐ Accident 6 ☐ Could not be
determined
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury

(Month, Day Year)

28b. Time of
Injury

M

28c. Injury at
Work?1 ☐ Yes 2 ☐ No28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
and manner stated.

29b. Signature and title of certifier

29c. License number

D23170

29d. Date signed (Month, Day, Year)

January 20, 2004

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Gita Bakshi, M.D. 9406 Old Georgetown Road, Bethesda, Maryland 20814

31. Date filed (Month, Day, Year)

JAN 22 2004

32. Registrar's Signature

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or item 23a or 28a-f show
any injury or other traumatic event, the Medical Examiner must be notified at
once.Physician
/Medical
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial transit

13

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

1- For
State
Registrar

2004 03906

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) MELVIN F. MARGOLIN			2. Date of Death Month Day Year JANUARY 17, 2004		3. Time of Death 7:50P M	
	4a. Facility Name (If not institution, give street and number) ROCKVILLE NURSING HOME			4b. City, Town, or Location of Death ROCKVILLE		4c. County of Death MONTGOMERY	
Funeral Director	5. Social Security Number 568-09-8900		6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		7. Age (In yrs. last birthday) 84 Yrs.		8. Date of Birth (Month, Day, Year) JUNE 6, 1919
	9. Birthplace (State or Foreign Country) CALIFORNIA		10a. State MARYLAND		10b. County MONTGOMERY		10c. City, Town or Location POTOMAC
To Be Completed by Funeral Director	10e. Street and Number #2 OLD CREEK COURT			10f. Zip Code 20854		10g. Citizen of What Country? UNITED STATES OF AMERICA	
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Date WWII		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: WHITE
To Be Completed by Physician/Medical Examiner	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 4		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) SENIOR VICE PRESIDENT		16b. Kind of Business/Industry FURNITURE MANUFACTURING		
	17. Father's Name (First, Middle, Last) AVRAM J. MARGOLIN			18. Mother's Name (First, Middle, Maiden Surname) POLINA MEDVIN			
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) ANGELA J. KUDON - DAUGHTER			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) #2 OLD CREEK COURT, POTOMAC, MD 20854			
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) GARDEN OF REMEMBRANCE		20c. Location - City or Town, State 01/19/04 CLARKSBURG, MD		
To Be Completed by Physician/Medical Examiner	21. Signature of Funeral Service Licensee 			22. Name and Address of Facility EDWARD SAGEL FUNERAL DIRECTION, INC. 1091 ROCKVILLE PIKE, ROCKVILLE, MD 20852			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. END STAGE RENAL DISEASE Due to (or as a consequence of): b. HYPERTENSIVE HEART DISEASE Due to (or as a consequence of): c. CORONARY HEART DISEASE Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last						Approximate Interval Between Onset and Death
To Be Completed by Physician/Medical Examiner	23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 9 <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) 9 <input type="checkbox"/> Unknown		23d. Date of delivery Month Day Year		
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown
To Be Completed by Physician/Medical Examiner	24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				
	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)				
To Be Completed by Physician/Medical Examiner	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
	28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)		
To Be Completed by Physician/Medical Examiner	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.						
	29b. Signature and title of certifier 		29c. License number D47330		29d. Date signed (Month, Day, Year) JANUARY 19, 2004		
To Be Completed by Physician/Medical Examiner	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) THOMAS JOSEPH MD, 50 W EDMONSTON DRIVE, ROCKVILLE, MD 20852						
	31. Date filed (Month, Day, Year) JAN 22 2004		32. Registrar's Signature 				

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

1- For
State
Registrar

2004 03907

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 23b-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

1. Decedent's Name (First, Middle, Last) SAMUEL C. MARCUS		2. Date of Death Month Day Year JANUARY 19, 2004		3. Time of Death 1615 M
4a. Facility Name (If not institution, give street and number) MONTGOMERY GENERAL HOSPITAL		4b. City, Town, or Location of Death OLNEY		4c. County of Death MONTGOMERY
5. Social Security Number 168-07-0351	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 85 Yrs.	8. Date of Birth (Month, Day, Year) MAY 24, 1918	9. Birthplace (State or Foreign Country) PENNSYLVANIA
Usual Residence of Decedent				
10a. State MARYLAND	10b. County MONTGOMERY	10c. City, Town or Location ROCKVILLE		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
10e. Street and Number 13417 KEATING STREET		10f. Zip Code 20853		10g. Citizen of What Country? U.S.A.
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: WWII		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:
14. Race - American Indian, Black, White, etc. Specify: WHITE		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <input type="checkbox"/> College (1-4 or 5+) <input checked="" type="checkbox"/> 4		
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) BIOSTATISTICIAN		16b. Kind of Business/Industry U.S. GOVERNMENT		
17. Father's Name (First, Middle, Last) ISAAC MARCUS		18. Mother's Name (First, Middle, Maiden Surname) JENNIE WEINER		
19a. Informant's Name/Relationship (Type, Print) RUTH A. MARCUS/WIFE		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 13417 KEATING STREET, ROCKVILLE, MARYLAND 20853		
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) PARKLAWN MENORAH GDNS		20c. Location - City or Town, State ROCKVILLE, MARYLAND
21. Signature of Funeral Service Licensee Donald C. Stottmeyer		22. Name and Address of Facility DANZANSKY-GOLDBERG MEMORIAL CHAPELS, INC. 1170 ROCKVILLE PIKE, ROCKVILLE, MARYLAND 20852		
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) BRAIN STEM INFARCTION Due to (or as a consequence of): ATRIAL FIBRILLATION Due to (or as a consequence of): Sequitally list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last				Approximate Interval Between Onset and Death
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <input type="checkbox"/> Unknown		23d. Date of delivery Month Day Year
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. DM CAD PVD				23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year) M		28b. Time of Injury 1 Yes <input checked="" type="checkbox"/> No
28c. Describe how injury occurred		28d. Location (Street and Number or Rural Route Number, City or Town, State)		
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				
29b. Signature and title of certifier Ramesh Patel		29c. License number D32243		29d. Date signed (Month, Day, Year) JANUARY 20, 2004
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) RAMESH PATEL M.D. 7525 GREENWAY CENTER PK #207, GREENBELT, MD 20770.				
31. Date filed (Month, Day, Year) JAN 22 2004		32. Registrar's Signature Sparks		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2004 03908

1- For
State
Registrar

Certificate of Death

Reg. No.

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Physician
/Medical
ExaminerFuneral
Director

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

1. Decedent's Name (First, Middle, Last) John David Miles		2. Date of Death Month Day Year January 13 2004		3. Time of Death 10:38 P M	
4a. Facility Name (If not institution, give street and number) Prince George's Hospital		4b. City, Town, or Location of Death Cheverly		4c. County of Death Prince George's	
5. Social Security Number 578-05-0562	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 88 Yrs.	8. Date of Birth (Month, Day, Year) Oct. 5, 1915	9. Birthplace (State or Foreign Country) Wash., D.C.	
Usual Residence of Decedent					
10a. State MD	10b. County Prince George's	10c. City, Town or Location Hyattsville		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
10e. Street and Number 6619 Stanton Road		10f. Zip Code 20784		10g. Citizen of What Country? USA	
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: WW II		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:	
14. Race - American Indian, Black, White, etc. Specify: White		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 10 College (1-4 or 5+) Pipefitter			
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Pipefitter		16b. Kind of Business/Industry Washington Navy Yard			
17. Father's Name (First, Middle, Last) James Miles		18. Mother's Name (First, Middle, Maiden Surname) Anne Hyde			
19a. Informant's Name/Relationship (Type, Print) Marvin Portnoy / son in law		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5150 8th St. NE Washington, D.C. 20011			
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Ft. Lincoln Cemetery		20c. Location - City or Town, State 1-17-2004 Brentwood, MD.	
21. Signature of Funeral Service Licensee 		22. Name and Address of Facility Beall Funeral Home 6512 NW Crain Highway Bowie, MD. 20715			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Multiorgan failure Due to (or as a consequence of): b. Lung Cancer Due to (or as a consequence of): c. Chronic obstructive lung disease Due to (or as a consequence of): d. Chronic lymphocytic leukemia					
23b. IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown					
23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <input type="checkbox"/> Unknown					
23d. Date of delivery Month Day Year					
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Hypertensive cardiovascular disease					
23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown					
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M	
28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred			
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.					
29b. Signature and title of certifier 		29c. License number D001285		29d. Date signed (Month, Day, Year) 1.14.04	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Hassan A. MOLAWI, MD 6005 Landover Rd. Chevy Chase MD 20785					
31. Date filed (Month, Day, Year) JAN 20 2004		32. Registrar's Signature 			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2004 03909

1- For
State
Registrar

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Fred Mathis				2. Date of Death Month 1 Day 11 Year 04				3. Time of Death 13:16 P M	
	4a. Facility Name (If not institution, give street and number) Washington Adventist Hospital				4b. City, Town, or Location of Death Takoma Park				4c. County of Death Montgomery	
Funeral Director	5. Social Security Number 023-28-9879		6. Sex 1 M 2 F		7. Age (In yrs. last birthday) 67 Yrs.		8. Date of Birth (Month, Day, Year) July 7, 1936		9. Birthplace (State or Foreign Country) Barnesville, GA.	
	10a. State D.C.		10b. County		10c. City, Town or Location Washington		10d. Inside City Limits 1 Yes 2 No			
To Be Completed by Funeral Director	10e. Street and Number 3900 16th. Street N.W. #512				10f. Zip Code 20011		10g. Citizen of What Country? USA			
	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Yes 2 No Specify:		14. Race - American Indian, Black, White, etc. Specify: Black			
To Be Completed by Physician/Medical Examiner	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 8 yrs.				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Educator		16b. Kind of Business/Industry D.C. Public Schools			
	17. Father's Name (First, Middle, Last) Edward Mathis				18. Mother's Name (First, Middle, Maiden Surname) Bernice Bush					
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) Milton Harris Cousin				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10000 Gate Parkway No. #525 Jacksonville, FL. 32246					
	20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Green Mount		Date 1-23-04		20c. Location - City or Town, State Barnesville, GA.			
To Be Completed by Physician/Medical Examiner	21. Signature of Funeral Service Licensee J.P. Marshall				22. Name and Address of Facility Marshall's Funeral Home 4217 9th. St. N.W. Washington, D.C. 20011					
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Pulmonary embolism				Approximate Interval Between Onset and Death					
To Be Completed by Physician/Medical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Advanced Acquired Immuno-deficiency Syndrome, Diabetes mellitus, hypertension									
	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown				23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify) 9 Unknown				23d. Date of delivery Month _____ Day _____ Year _____	
To Be Completed by Physician/Medical Examiner	Part II. Other significant conditions (contributing to death but not resulting in the underlying cause given in Part I.) Advanced Acquired Immuno-deficiency Syndrome, Diabetes mellitus, hypertension				23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown					
	25. Was case referred to medical examiner? 1 Yes 2 No		Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA		Other: 4 Nursing Home 5 Residence 6 Other (Specify)		24a. Was an autopsy performed? 1 Yes 2 No		24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No	
To Be Completed by Physician/Medical Examiner	27. Manner of Death 1 Natural 5 Pending investigation 2 Accident 6 Could not be determined 3 Suicide 4 Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 Yes 2 No		28d. Describe how injury occurred	
	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. Signature and title of certifier NEGUSSE		29c. License number D45471		29d. Date signed (Month, Day, Year) 1/11/04	
To Be Completed by Physician/Medical Examiner	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) YEHEYIS NEGUSSE				Washington Adv. Hosp.					
	31. Date filed (Month, Day, Year) JAN 23 2004				32. Registrar's Signature Beck & Spore					

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

perm. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural," or item 23e of 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For Independent State Registrar

Items 23a, 27 per ME, G828, 02/13/04 dbb

Certificate of Death

Reg. No.

2004 03910

3141

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Physician /Medical Examiner	Funeral Director
To Be Completed by Funeral Director	
To Be Completed by Physician/Medical Examiner	

1. Decedent's Name (First, Middle, Last) Robert Eugene McClain				2. Date of Death Month JANUARY Day 24, Year 2004		3. Time of Death 2226 P M			
4a. Facility Name (If not institution, give street and number) PRINCE GEORGES HOSPITAL CENTER			4b. City, Town, or Location of Death CHEVERLY			4c. County of Death PRINCE GEORGES			
5. Social Security Number 578-92-5703		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 38 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) 5/21/65		9. Birthplace (State or Foreign Country) N. Carolina	
Usual Residence of Decedent									
10a. State Md.		10b. County P.G.		10c. City, Town or Location Forestville			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
10e. Street and Number 7529 Val Lane				10f. Zip Code 20747		10g. Citizen of What Country? U.S.A.			
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: Black		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 10th College (1-4 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Truck Driver			16b. Kind of Business/Industry Private Industry		
17. Father's Name (First, Middle, Last) Robert McClain				18. Mother's Name (First, Middle, Maiden Surname) Bertha Broadie					
19a. Informant's Name/Relationship (Type, Print) Elaine A. McClain/Wife				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7529 Val Lane, Forestville, Md. 20747					
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Harmony Mem. Park			Date 1/31/04		20c. Location - City or Town, State Landover, Md.		
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility H.S. Washington & Sons Co., Inc. 4925 Burroughs Ave., N.E., Wash., D.C. 20019					
23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Diabetic Ketoacidosis Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last a. Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d.									Approximate Interval Between Onset and Death
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Unknown <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Other (Specify)					23d. Date of delivery Month Day Year		
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown			
24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No						24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No			
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input checked="" type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred	
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)					
29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.									
29b. Signature and title of certifier 				29c. License number OCME		29d. Date signed (Month, Day, Year) JANUARY 25, 2004			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Tasha Z Greenberg M.D. 111 Penn Street, Baltimore, Maryland 21201									
31. Date filed (Month, Day, Year) JAN 29 2004				32. Registrar's Signature 					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

1- For State Registrar

2004 03911

Physician / Medical Examiner	1. Decedent's Name (First, Middle, Last) Minhthuy Nguyen				2. Date of Death Month Day Year January 19 2004		3. Time of Death 9:10 PM	
	4a. Facility Name (If not institution, give street and number) Shady Grove Adventist Hospital				4b. City, Town, or Location of Death Rockville		4c. County of Death Montgomery	
Funeral Director	5. Social Security Number 586-48-6299	6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 42 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) Oct. 28, 1961	9. Birthplace (State or Foreign Country) Viet Nam	
	Usual Residence of Decedent							
To Be Completed by Funeral Director	10a. State Maryland	10b. County Montgomery	10c. City, Town or Location Gaithersburg			10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
	10e. Street and Number 20034 Mattingly Terrace			10f. Zip Code 20879		10g. Citizen of What Country? U.S.A.		
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: Asian	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 16+		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) homemaker		16b. Kind of Business/Industry own home			
To Be Completed by Physician/Medical Examiner	17. Father's Name (First, Middle, Last) Phu Tran				18. Mother's Name (First, Middle, Maiden Surname) Minhtam Do			
	19a. Informant's Name/Relationship (Type, Print) Long K. Nguyen / husband				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20034 Mattingly Terrace, Gaithersburg, MD 20879			
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Gate of Heaven Cem.		Date 1-24-2004		20c. Location - City or Town, State Silver Spring, MD	
	21. Signature of Funeral Service Licensee 		22. Name and Address of Facility Hines-Rinaldi Funeral Home, Inc. 11800 New Hampshire Ave., Silver Spring, MD 20904					
Physician / Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. metastatic lung cancer Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of):						Approximate Interval Between Onset and Death months	
	23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 9 <input type="checkbox"/> Unknown						23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) 9 <input type="checkbox"/> Unknown	
	23d. Date of delivery Month Day Year							
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown	
To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
	28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
	29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier Alicia J. Mistry MD		29c. License number D59738		29d. Date signed (Month, Day, Year) January 20, 2004	
State Registrar	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Alicia Mistry 9901 Medical Center Drive Rockville, MD 20850							
	31. Date filed (Month, Day, Year) JAN 23 2004		32. Registrar's Signature 					

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

2004 03912

1- For State Registrar

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Helen M. Newman				2. Date of Death Month Day Year January 20, 2004				3. Time of Death 8:32 a M	
	4e. Facility Name (If not institution, give street and number) Montgomery General Hospital				4b. City, Town, or Location of Death Olney				4c. County of Death Montgomery	
Funeral Director	5. Social Security Number 117-26-5760		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 69 Yrs.		8. Date of Birth (Month, Day, Year) Aug. 27, 1934		9. Birthplace (State or Foreign Country) Connecticut	
	Usual Residence of Decedent				10a. State Maryland		10b. County Montgomery		10c. City, Town or Location Olney	
To Be Completed by Funeral Director	10a. State Maryland				10b. County Montgomery				10c. City, Town or Location Olney	
	10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				10e. Street and Number 5020 Tothill Drive				10f. Zip Code 20832	
To Be Completed by Physician/Medical Examiner	10g. Citizen of What Country? USA				11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced				12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:	
	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: White				15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 4	
To Be Completed by Physician/Medical Examiner	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Computer Engineer				16b. Kind of Business/Industry Goddard Space Flight Center				17. Father's Name (First, Middle, Last) James Power	
	18. Mother's Name (First, Middle, Maiden Surname) Rita Mulvey				19a. Informant's Name/Relationship (Type, Print) Phillip A. Newman/ Husband				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5020 Tothill Drive, Olney, MD 20832	
To Be Completed by Physician/Medical Examiner	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) All Souls Cemetery				20c. Location - City or Town, State Germantown, Maryland	
	21. Signature of Funeral Service Licensee James J. Ooley				22. Name and Address of Facility Francis J. Collins Funeral Home Inc. 500 University Blvd. W, Silver Spring, MD 20901				23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Aortic Rupture Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of):	
To Be Completed by Physician/Medical Examiner	23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 9 <input type="checkbox"/> Unknown				23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) 9 <input type="checkbox"/> Unknown				23d. Date of delivery Month Day Year	
	23e. Did tobacco use contribute to the cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown				24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)				27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined	
	28a. Date of Injury (Month, Day Year)				28b. Time of Injury M				28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
To Be Completed by Physician/Medical Examiner	28d. Describe how injury occurred				28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)	
	29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				29b. Signature and title of certifier Richard A. Silva				29c. License number D053864	
To Be Completed by Physician/Medical Examiner	29d. Date signed (Month, Day, Year) January 21, 2004				30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Richard A. Silva 18109 Prince Philip Drive, #100, Olney, MD 20832				31. Date filed (Month, Day, Year) JAN 22 2004	
	32. Registrar's Signature [Signature]				33. Registrar's Signature [Signature]				34. Registrar's Signature [Signature]	

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

Certificate of Death

Reg. No.

2004 03913

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,


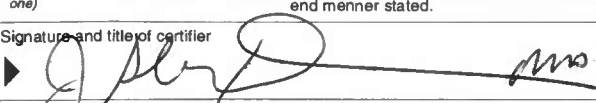

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Physician
/Medical
ExaminerFuneral
Director

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

1. Decedent's Name (First, Middle, Last) Walter Francis Neary				2. Date of Death Month Day Year January 15, 2004		3. Time of Death 5:45 pm	
4a. Facility Name (If not institution, give street and number) Shady Grove Adventist Hospital				4b. City, Town, or Location of Death Rockville		4c. County of Death Montgomery	
5. Social Security Number 043-07-1284		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 97 Yrs.		8. Date of Birth (Month, Day, Year) Oct. 15, 1906	
9. Birthplace (State or Foreign Country) Connecticut		10a. State Maryland		10b. County Montgomery		10c. City, Town or Location Rockville	
10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		10e. Street and Number 303 Adclare Road		10f. Zip Code 20850		10g. Citizen of What Country? USA	
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: WWII		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) College		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Programs Officer		16b. Kind of Business/Industry U.S. Department of Labor			
17. Father's Name (First, Middle, Last) James Neary				18. Mother's Name (First, Middle, Maiden Surname) Jane McNamara			
19a. Informant's Name/Relationship (Type, Print) Judith A. Mahachek/Daughter				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 17812 Hidden Garden Lane, Ashton, MD 20861			
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Gate of Heaven Cemetery		Date Jan. 19 2004		20c. Location - City or Town, State Silver Spring, MD	
21. Signature of Funeral Service Licensee 		22. Name and Address of Facility Francis J. Collins Funeral Home Inc. 500 University Blvd. W., Silver Spring, MD 20901					
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Aspiration Pneumonia Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last {							
23b. Approximate Interval Between Onset and Death 20 days							
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Congestive Heart Failure Myocardial Infarction						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown	
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No						24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No	
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA		26. Place of Death (Check only one) Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No	
28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.							
29b. Signature and title of certifier 				29c. License number D58681		29d. Date signed (Month, Day, Year) January 16, 2004	
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) Dr. Jude Alexander 1201 Seven Locks Road, #111, Rockville, MD 20854							
31. Date filed (Month, Day, Year) JAN 20 2004		32. Registrar's Signature 					

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2004 03914

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

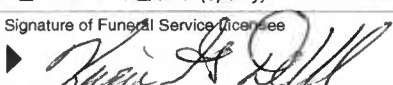


To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Physician
/Medical
ExaminerFuneral
Director

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

1. Decedent's Name (First, Middle, Last) Josephine Natoli		2. Date of Death Month January Day 13 , Year 2004		3. Time of Death 9:00 AM	
4a. Facility Name (If not institution, give street and number) Millennium Health and Rehabilitation		4b. City, Town, or Location of Death Silver Spring		4c. County of Death Montgomery	
5. Social Security Number 578-80-1752		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 96 Yrs.	
8. Date of Birth (Month, Day, Year) June 13, 1907		9. Birthplace (State or Foreign Country) Italy			
Usual Residence of Decedent					
10a. State D.C.		10b. County None		10c. City, Town or Location Washington	
10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No					
10e. Street and Number 2223 38th Street, NW		10f. Zip Code 20007		10g. Citizen of What Country? USA	
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:	
14. Race - American Indian, Black, White, etc. Specify: White					
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4or 5+) Homemaker		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker		16b. Kind of Business/Industry Own Home	
17. Father's Name (First, Middle, Last) Anthony Padua		18. Mother's Name (First, Middle, Maiden Surname) Rose Valenti			
19a. Informant's Name/Relationship (Type, Print) Rose A. Pizzola/Daughter		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2223 38th St., NW., Washington, DC 20007			
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Ft. Lincoln Cemetery		20c. Location - City or Town, State Brentwood, Maryland	
21. Signature of Funeral Service licensee 		22. Name and Address of Facility DeVol Funeral Home 2222 Wisconsin Ave., N.W. Washington, D.C. 20007			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.					
Immediate Cause (Final disease or condition resulting in death)					
a. Cardiopulmonary Failure Due to (or as a consequence of):					
b. Congestive Heart Failure Due to (or as a consequence of):					
c. Hypertension Due to (or as a consequence of):					
d. Aortic Stenosis Due to (or as a consequence of):					
23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown					
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No					
24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No					
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Dementia					
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No					
26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M	
28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred			
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.					
29b. Signature and title of certifier 		29c. License number D00-51520		29d. Date signed (Month, Day, Year) January 15, 2004	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Bahram Pishdad, M.D. 1328 Southern Ave., S.E. #310 Wash., D.C. 20032					
31. Date filed (Month, Day, Year) JAN 20 2004		32. Registrar's Signature 			

State
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2004 03915

1- For
State
Registrar

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Dorothy A. Norris		2. Date of Death Month: 01/16/2004 Day: Year:		3. Time of Death 5:52 P M
	4a. Facility Name (If not institution, give street and number) Southern Maryland Hospital Center		4b. City, Town, or Location of Death Clinton		4c. County of Death Prince George's
Funeral Director	5. Social Security Number 579-20-0435	6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 80 Yrs.	8. Date of Birth (Month, Day, Year) 06/01/1923	9. Birthplace (State or Foreign Country) Washington, DC
	Usual Residence of Decedent				
To Be Completed by Funeral Director	10a. State Maryland	10b. County Prince George's	10c. City, Town or Location Suitland		10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
	10e. Street and Number 6023 Lucente Avenue		10f. Zip Code 20746		10g. Citizen of What Country? USA
To Be Completed by Physician/Medical Examiner	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:
	14. Race - American Indian, Black, White, etc. Specify: White		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 10 College (1-4 or 5+) 10		
To Be Completed by Physician/Medical Examiner	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker		16b. Kind of Business/Industry In Home		
	17. Father's Name (First, Middle, Last) Joseph Sichert Sr.		18. Mother's Name (First, Middle, Maiden Surname) Annabell UNKNOWN		
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) Josephine Simmons / Executor		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1125 Wentworth Drive Oxon Hill, Maryland 20745		
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) MD. Veterans Cemetery		20c. Location - City or Town, State Cheltenham, Maryland
To Be Completed by Physician/Medical Examiner	21. Signature of Funeral Service Licensee 		22. Name and Address of Facility George P. Kalas Funeral Home P.A. 6160 Oxon Hill Road Oxon Hill, Maryland 20745		
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) SEPTIC SHOCK a. Due to (or as a consequence of): SEPTICEMIA b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of):				
To Be Completed by Physician/Medical Examiner	23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 9 <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify)		23d. Date of delivery Month: Day: Year:
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				
To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28. Date of Injury (Month, Day, Year) 28b. Time of Injury M 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 28d. Describe how injury occurred 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)		
To Be Completed by Physician/Medical Examiner	29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				
	29b. Signature and title of certifier 		29c. License number D0042707		29d. Date signed (Month, Day, Year) 01-17-2004
To Be Completed by Physician/Medical Examiner	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) George B. Bren MD 8926 Woodyard Road #601 Clinton, Maryland 20735				
	31. Date filed (Month, Day, Year) JAN 21 2004		32. Registrar's Signature 		

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28e-f show injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2004 03916

1- For
State
RegistrarPhysician
/Medical
ExaminerFuneral
Director

1. Decedent's Name (First, Middle, Last)

Dale Kenneth Nonnemacher

2. Date of Death

January 15 2004

3. Time of Death

2:00 A M

4a. Facility Name (If not institution, give street and number)

2522 Knighthill Lane

4b. City, Town, or Location of Death

Bowie

4c. County of Death

Prince George's

5. Social Security Number

218-28-0997

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

72 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
Sept. 8, 1931

9. Birthplace (State or Foreign Country)

Pennsylvania

Usual Residence of Decedent

10a. State

MD

10b. County

Prince George's

10c. City, Town or Location

Bowie

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

2522 Knighthill Lane

10f. Zip Code

20715

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☒ Yes 2 ☐ No

If Yes, Give

Year or Dates: 1951-55

13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: White

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

5+

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Teacher

16b. Kind of Business/Industry

Public School

17. Father's Name (First, Middle, Last)

Freeman Nonnemacher

18. Mother's Name (First, Middle, Maiden Surname)

Helen Margaret Unangst

19a. Informant's Name/Relationship (Type, Print)

Elizabeth A. Nonnemacher/spouse

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2522 Knighthill Lane Bowie, MD. 20715

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

MD. Veterans Cemetery

Date

1-21-2004

20c. Location - City or Town, State

Cheltenham, MD.

21. Signature of Funeral Service Licensee

E. Juan Powell

22. Name and Address of Facility

Beall Funeral Home

6512 NW Crain Highway Bowie, MD. 20715

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

Hepatocellular carcinoma

Approximate
Interval Between
Onset and Death

1 year

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

a. Due to (or as a consequence of):

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

IF FEMALE:

23b. Was decedent pregnant
in the past 12 months?1 ☐ Yes 2 ☐ No
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown3 ☐ Ectopic pregnancy
5 ☐ Other (specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an
autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings available
prior to completion of cause of
death?1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death Check only one

Other: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending
investigation
2 ☐ Accident 6 ☐ Could not be
determined
3 ☐ Suicide 4 ☐ Homicide28a. Date of Injury
(Month, Day Year)28b. Time of
Injury28c. Injury at
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
and manner stated.

29b. Signature and title of certifier

Kevin J. Shannon, M.D.

29c. License number

D53829

29d. Date signed (Month, Day, Year)

January 16, 2004

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Kevin J. Shannon, M.D. 7525 Greenway Center Dr. Greenbelt, MD. 20770

31. Date filed (Month, Day, Year)

JAN 20 2004

32. Registrar's Signature

[Signature]

State
Registrar

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show
any injury or other traumatic event, the Medical Examiner must be notified at
once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2004 03917

Certificate of Death

Reg. No.

1- For
State
RegistrarPhysician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

ANNIE BELL NOBLE

2. Date of Death

Month Day Year
JANUARY 20, 2004

3. Time of Death

11:21P M

Funeral
Director

4a. Facility Name (If not institution, give street and number)

SOUTHERN MARYLAND HOSPITAL CENTER

4b. City, Town, or Location of Death

CLINTON

4c. County of Death

PRINCE GEORGES

5. Social Security Number

226 09 3646

6. Sex

1 ☐ M ☒ F

7. Age (In yrs. last birthday)

98 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

OCT. 05, 1905

9. Birthplace (State or Foreign Country)

MILTON, NC

Usual Residence of Decedent

10a. State

MARYLAND

10b. County

PRINCE GEORGES

10c. City, Town or Location

CLINTON

10d. Inside City Limits

☒ Yes 2 ☐ No

10e. Street and Number

5710 BUTTERFIELD DRIVE

10f. Zip Code

20735

10g. Citizen of What Country?

UNITED STATES

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes ☒ No
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: BLACK

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

5TH

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

FACTORY WORKER

16b. Kind of Business/Industry

PRIVATE

17. Father's Name (First, Middle, Last)

UNKNOWN

18. Mother's Name (First, Middle, Maiden Surname)

MARTHA MITCHELL

19a. Informant's Name/Relationship (Type, Print)

PHYLLIS NOBLE / GRAND DAUGHTER

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

5710 BUTTERFIELD DRIVE CLINTON, MD 20735

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

LINCOLN CEMETERY

Date

01/26/2004

20c. Location - City or Town, State

SUITLAND, MD

21. Signature of Funeral Service Licensee

P. Marshall

22. Name and Address of Facility

MARSHALL'S FUNERALHOME OF MARYLAND, INC.
4308 SUITLAND ROAD SUITLAND, MD 2074623a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

a. Due to (or as a consequence of):

Community Acquired pneumonia

b. Due to (or as a consequence of):

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

c. Due to (or as a consequence of):

d.

IF FEMALE:

23b. Was decedent pregnant
in the past 12 months?
1 ☐ Yes 2 ☒ No
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy
4 ☐ Pregnant at time of death 5 ☐ Other (specify)
9 ☐ Unknown23d. Date of delivery
Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Anemia

Chronic renal insufficiency

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an
autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings available
prior to completion of cause of
death?1 ☐ Yes 2 ☒ No25. Was case referred to medical
examiner?
1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending
investigation
2 ☐ Accident 6 ☐ Could not be
determined
3 ☐ Suicide
4 ☐ Homicide28a. Date of Injury
(Month, Day Year)28b. Time of
Injury28c. Injury at
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
and manner stated.

29b. Signature and title of certifier

A Rahimian MD

29c. License number

D0052994

29d. Date signed (Month, Day, Year)

1/21/2004

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ALI RAHIMIAN MD 7501 SURRATTS ROAD 205 CLINTON MD 20735

31. Date filed (Month, Day, Year)

JAN 22 2004

Registrar's Signature

Kuan & Spiller

State
Registrar

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show
any injury or other traumatic event, the Medical Examiner must be notified at
once.Physician
/Medical
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit
certificate.

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2004 03918

1- For State Registrar

Physician /Medical Examiner

Funeral Director

To Be Completed by Funeral Director

Medical Certification; To Be Completed by Physician/Medical Examiner

1. Decedent's Name (First, Middle, Last) QUNNIE NELSON		2. Date of Death Month 1 Day 17 Year 2004		3. Time of Death 9:45 A M	
4a. Facility Name (If not institution, give street and number) 12209 WESTMONT LANE		4b. City, Town, or Location of Death BOWIE		4c. County of Death PRINCE GEORGE'S	
5. Social Security Number 230-26-6767	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 75 Yrs.	8. Date of Birth (Month, Day, Year) 3 22 1928	9. Birthplace (State or Foreign Country) VIRGINIA	
Usual Residence of Decedent					
10a. State MD	10b. County PRINCE GEORGE'S	10c. City, Town or Location BOWIE		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
10e. Street and Number 12209 WESTMONT LANE		10f. Zip Code 20715		10g. Citizen of What Country? U.S.A.	
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 10th College (1-4or 5+) 		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) ENVIROMENTAL SERVICE		16b. Kind of Business/Industry GOVERNMENT	
17. Father's Name (First, Middle, Last) WATSON JERSON REDWOOD			18. Mother's Name (First, Middle, Maiden Surname) ELEANOR F. HENDERSON		
19a. Informant's Name/Relationship (Type, Print) BRENDA PRESTON/DAUGHTER		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12209 WESTMONT LANE BOWIE, MARYLAND 20715			
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) HARMONY CEMETERY		20c. Location - City or Town, State 1-24-04 LANDOVER, MARYLAND	
21. Signature of Funeral Service licensee 		22. Name and Address of Facility J. B. JENKINS FUNERAL HOME 7474 LANDOVER ROAD LANDOVER, MARYLAND 20785			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last					Approximate Interval Between Onset and Death
a. Congestive Cardiomyopathy Due to (or as a consequence of): b. Congestive Heart Failure Due to (or as a consequence of): c. Hypertension Due to (or as a consequence of): d. Diabetes Mellitus Due to (or as a consequence of):					
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <input type="checkbox"/> Unknown		23d. Date of delivery Month Day Year	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown	
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M <input type="checkbox"/> Yes <input type="checkbox"/> No	
		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		28d. Describe how injury occurred	
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)	
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.					
29b. Signature and title of certifier 		29c. License number MD 19689		29d. Date signed (Month, Day, Year) 01/21/2004	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ANITA CLAYTON M.D. 1011 NORTH CAPITAL STREET N.W. WASHINGTON DC 20002					
31. Date filed (Month, Day, Year) JAN 23 2004		32. Registrar's Signature 			

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permt. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2004 03919

1- For
State
RegistrarPhysician
/Medical
ExaminerFuneral
Director

1. Decedent's Name (First, Middle, Last)

ROBERT STANLEY OAKES

2. Date of Death

January 19, 2004

3. Time of Death

3:05 P^M

4a. Facility Name (If not institution, give street and number)

Montgomery General Hospital

4b. City, Town, or Location of Death

Olney

4c. County of Death

Montgomery

5. Social Security Number

578-20-4291

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

81

Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

July 19, 1922

9. Birthplace (State or Foreign Country)

Colorado

Usual Residence of Decedent

10a. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Silver Spring

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

3632 Edelman Terrace

10f. Zip Code

20906

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☒ Yes 2 ☐ No
If Yes, Give Year or Date: 1942 to 1945

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

4

16a. Decedent's Usual Occupation

(Give kind of work done during most of working life. DO NOT use retired)

Photographer

16b. Kind of Business/Industry

National Geographic

17. Father's Name (First, Middle, Last)

Walter F. Oakes

18. Mother's Name (First, Middle, Maiden Surname)

Ruth Phennah

19a. Informant's Name/Relationship (Type, Print)

Patricia Oakes/Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

3632 Edelman Terrace, Silver Spring, Maryland 20906

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Metropolitan Crematory 01/21/2004 Alexandria, Virginia

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

Richard D. Fitzgerald

22. Name and Address of Facility

MONEY & KING FUNERAL HOME, INC.
171 W. Maple Ave., Vienna, Va. 22180

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

ANXIOUS ENCEPHALOPATHY

Approximate Interval Between Onset and Death
36 HR.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

- a. Due to (or as a consequence of):
- b. Due to (or as a consequence of):
- c. Due to (or as a consequence of):
- d. Due to (or as a consequence of):

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☐ No
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 5 ☐ Other (specify)
9 ☐ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural 5 ☐ Pending investigation
2 ☐ Accident 6 ☐ Could not be determined
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Dr. J. Mgt. MD

29c. License number

D23630

29d. Date signed (Month, Day, Year)

January 19, 2004

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

FRANK J. MAYU MD 16220 FREEDOM RD #213, Bethesda, MD 20817

31. Date filed (Month, Day, Year)

JAN 22 2004

32. Registrar's Signature

*Benjamin B. Sparks*State
Registrar

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial/transit

To Be Completed by Funeral Director

Medical Certification; To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2004 03920

AMEND#1&3 per MD1/28/04, BW, McCo

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) NEVA IRENE PURSELL			2. Date of Death Month Day Year JANUARY 18, 2004		3. Time of Death AM PM 2:45 PM		
	NEVA IRENE PURSELL							
Funeral Director	4a. Facility Name (If not institution, give street and number) ROCKVILLE NURSING HOME			4b. City, Town, or Location of Death ROCKVILLE		4c. County of Death MONTGOMERY		
To Be Completed by Funeral Director	5. Social Security Number 214-48-9870		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 96 Yrs.		8. Date of Birth (Month, Day, Year) Sept 7, 1907	
							9. Birthplace (State or Foreign Country) Nebraska	
To Be Completed by Physician/Medical Examiner	Usual Residence of Decedent			10c. City, Town or Location		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
	10a. State Maryland			10b. County Montgomery				
To Be Completed by Physician/Medical Examiner	10e. Street and Number 3234 Hewitt Ave, #20			10f. Zip Code 20906		10g. Citizen of What Country? USA		
To Be Completed by Physician/Medical Examiner	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White	
To Be Completed by Physician/Medical Examiner	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <input type="checkbox"/> College (1-4 or 5+) <input checked="" type="checkbox"/> 2			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker		16b. Kind of Business/Industry Own Home		
To Be Completed by Physician/Medical Examiner	17. Father's Name (First, Middle, Last) Earl Emmett Lackey			18. Mother's Name (First, Middle, Maiden Surname) Julia Christina Nickel				
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) Nancy P. Schulze/Daughter			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 764 Azalea Dr, Rockville, MD 20850				
To Be Completed by Physician/Medical Examiner	20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) Fort Lincoln Crematory		20c. Location - City or Town, State Jan 22, 2004 Brentwood, MD		
To Be Completed by Physician/Medical Examiner	21. Signature of Funeral Service Licensee <i>Raisa Buttery</i>			22. Name and Address of Facility Hines-Rinaldi Funeral Home 11800 New Hampshire Ave, Silver Spring, MD 20904				
To Be Completed by Physician/Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Congestive Heart Failure						Approximate Interval Between Onset and Death 2 weeks	
	Due to (or as a consequence of): a. b. c. d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last							
To Be Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Senile Dementia						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown	
To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)				
To Be Completed by Physician/Medical Examiner	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined			28a. Date of Injury (Month, Day Year)		28b. Time of Injury M <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
To Be Completed by Physician/Medical Examiner	28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			28d. Describe how injury occurred		28e. Location (Street and Number or Rural Route Number, City or Town, State)		
To Be Completed by Physician/Medical Examiner	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.							
To Be Completed by Physician/Medical Examiner	29b. Signature and title of certifier <i>Misty Johns</i>			29c. License number D31839		29d. Date signed (Month, Day, Year) January 21, 2004		
To Be Completed by Physician/Medical Examiner	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Christopher C. Dunford, MD 615 W. Montgomery Ave, Rockville, MD 20850							
To Be Completed by Physician/Medical Examiner	31. Date filed (Month, Day, Year) JAN 22 2004			32. Registrar's Signature <i>Sparks</i>				

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene
Certificate of Death

Reg. No.

2004 03921

1- For
State
Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Donald Lee Pugh				2. Date of Death Month January Day 14 , Year 2004		3. Time of Death 9:00 A^M	
	4a. Facility Name (If not institution, give street and number) Shady Grove Adventist Hospital				4b. City, Town, or Location of Death Rockville		4c. County of Death Montgomery	
Funeral Director	5. Social Security Number 577-44-9258		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 69 Yrs.		8. Date of Birth (Month, Day, Year) Aug. 26, 1934	
	9. Birthplace (State or Foreign Country) Maryland		10a. State Maryland		10b. County Montgomery		10c. City, Town or Location Rockville	
10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		10e. Street and Number 13409 Crispin Way		10f. Zip Code 20853		10g. Citizen of What Country? United States		
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: Korea		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Cabinet Maker		16b. Kind of Business/Industry Custom Furniture				
17. Father's Name (First, Middle, Last) George A. Pugh				18. Mother's Name (First, Middle, Maiden Surname) Jane Nichols				
19a. Informant's Name/Relationship (Type, Print) Helen B. Pugh/Wife				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 13409 Crispin Way, Rockville, Maryland 20853				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Parklawn Memorial Park		Date January 20, 2004		20c. Location - City or Town, State Rockville, Maryland		
21. Signature of Funeral Service Licensee 		22. Name and Address of Facility Robert A. Pumphrey Funeral Home/Chase, Inc. 1755 Wisconsin Ave., Bethesda, MD 20814-3501		23. Date of delivery Month January Day 20 Year 2004		23d. Date of delivery Month January Day 20 Year 2004		
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Non a wave myocardial infarction Due to (or as a consequence of): b. Septic shock Due to (or as a consequence of): c. Toxic encephalopathy Due to (or as a consequence of): d. End stage Renal Disease Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last								
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Unknown		23d. Date of delivery Month January Day 20 Year 2004		23e. Date of delivery Month January Day 20 Year 2004		
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Hypertension Diabetes Mellitus				23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown				
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year) January 14, 2004		
28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		
28f. Location (Street and Number or Rural Route Number, City or Town, State)		29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier 		29c. License number D41162		
29d. Date signed (Month, Day, Year) January 14, 2004		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) V. Ganthi MD 19529 Doctor Drive Germantown MD 20874		31. Date filed (Month, Day, Year) JAN 20 2004		32. Registrar's Signature 		

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

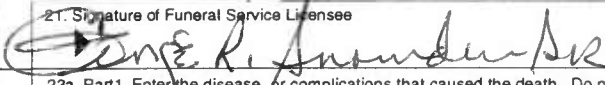
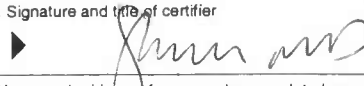
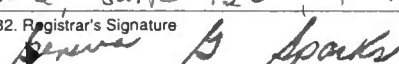
State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

1- For
State
Registrar

2004 03922

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) LEON PRESBURY				2. Date of Death Month 11 , Day 11 , Year 2004		3. Time of Death 2:44 P M	
	4a. Facility Name (If not institution, give street and number) Laurel Regional Hospital				4b. City, Town, or Location of Death Laurel		4c. County of Death PRINCE GEORGES	
Funeral Director	5. Social Security Number 219-34-9767		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 67 Yrs.		8. Date of Birth (Month, Day, Year) Sept. 27, 1936	
	9. Birthplace (State or Foreign Country) Maryland		10a. State MD		10b. County Montgomery		10c. City, Town or Location Silver Spring	
To Be Completed by Funeral Director	10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		10e. Street and Number 13827 Castle Blvd., #34		10f. Zip Code 20904		10g. Citizen of What Country? U.S.A.	
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: Black	
To Be Completed by Physician/Medical Examiner	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 10th		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Auto Mechanic		16b. Kind of Business/Industry Auto Services			
	17. Father's Name (First, Middle, Last) Winfield Presbury		18. Mother's Name (First, Middle, Maiden Surname) Dora Bonds		19a. Informant's Name/Relationship (Type, Print) Brenda Presbury (sister-in-law)			
Physician /Medical Examiner	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11322 Kettering Pl., Upper Marlbor, MD 20774		20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Ash Memorial Cem		20c. Location - City or Town, State 1/21/04 Sandy Spring, MD	
	21. Signature of Funeral Service Licensee 		22. Name and Address of Facility SNOWDEN FUNERAL HOME, P.A.		22. Name and Address of Facility 246 N. Wash. St., Rockville, MD 20850			
To Be Completed by Physician/Medical Examiner	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		a. Sudden Cardiac Death Due to (or as a consequence of):		Approximate Interval Between Onset and Death			
	b. Possible Arrhythmogenic Death Due to (or as a consequence of):		c. Atherosclerotic Heart Disease Due to (or as a consequence of):		d. Possible Coronary Artery Disease			
To Be Completed by Physician/Medical Examiner	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Unknown		3 <input type="checkbox"/> Ectopic pregnancy 5 <input type="checkbox"/> Other (Specify)		23d. Date of delivery Month 11 , Day 13 , Year 2004	
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Hypertensive Heart Disease Diabetes Mellitus Type 2 Renal Insufficiency		25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined	
To Be Completed by Physician/Medical Examiner	28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred	
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)		29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.			
To Be Completed by Physician/Medical Examiner	29b. Signature and title of certifier 		29c. License number 20036115		29d. Date signed (Month, Day, Year) 11/13/04			
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 7616 Carroll Avenue, Suite 420, Takoma Park, MD 20912		31. Date filed (Month, Day, Year) JAN 22 2004		32. Registrar's Signature 			

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2004 03923

1- For
State
RegistrarPhysician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Jeanne Ann Potter

2. Date of Death

January 16, 2004

3. Time of Death

2:50 A.M.

4a. Facility Name (If not institution, give street and number)

Suburban Hospital

4b. City, Town, or Location of Death

Bethesda

4c. County of Death

Montgomery

Funeral
Director

5. Social Security Number

226-44-1114

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

73

Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

Jan. 30, 1930

9. Birthplace (State or Foreign Country)

Virginia

Usual Residence of Decedent

10a. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Bethesda

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

9820 Parkwood Drive

10f. Zip Code

20814

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: White

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

4

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

William L. Phalen

18. Mother's Name (First, Middle, Maiden Surname)

Reba Lough

19a. Informant's Name/Relationship (Type, Print)

Michael Potter / Husband

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

9820 Parkwood Drive, Bethesda, Maryland 20814

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)Montgomery
Crematorium, Inc

Date

January 18,
2004

20c. Location - City or Town, State

Bethesda, Maryland

21. Signature of Funeral Service Licensee

M01353

22. Name and Address of Facility Robert A. Pumphrey Funeral Home/
Bethesda-Chevy Chase, Inc. 755 Wisconsin Avenue
Bethesda, Maryland 2081423a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)a. Seizure disorder

Due to (or as a consequence of):

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate
Interval Between
Onset and Death

1 week

IF FEMALE:

23b. Was decedent pregnant
in the past 12 months?1 ☐ Yes 2 ☒ No
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown3 ☐ Ectopic pregnancy
5 ☐ Other (Specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

PneumothoraxClostridium difficile colitis

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an
autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings available
prior to completion of cause of
death?1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending
investigation
2 ☐ Accident 6 ☐ Could not be
determined
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury

(Month, Day Year)

28b. Time of
Injury

M

28c. Injury at
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
and manner stated.

29b. Signature and title of certifier

29c. License number

D0060117

29d. Date signed (Month, Day, Year)

Jan 16, 2004

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Eric Park, MD 9901 Medical Center Drive, Rockville, MD 20850

31. Date filed (Month, Day, Year)

JAN 20 2004

32. Registrar's Signature

Benjamin S. Sparks

State
Registrar

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28e-1 show
any injury or other traumatic event, the Medical Examiner must be notified at
once.Physician
/Medical
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit
document.1/16/04 0350 AM
Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

1- For State Registrar

2004 03924

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

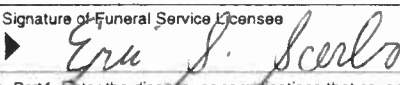

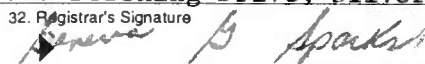
permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

1. Decedent's Name (First, Middle, Last) John Thomas Perone Sr.		2. Date of Death Month January Day 17 Year 2004		3. Time of Death 12:12 p^M	
4a. Facility Name (If not institution, give street and number) Holy Cross Hospital		4b. City, Town, or Location of Death Silver Spring		4c. County of Death Montgomery	
5. Social Security Number 577-09-2447	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 85 Yrs.	8. Date of Birth (Month, Day, Year) Jan. 12, 1919		9. Birthplace (State or Foreign Country) Washington, DC
Usual Residence of Decedent					
10a. State Maryland	10b. County Montgomery	10c. City, Town or Location Silver Spring		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
10e. Street and Number 10303 Colesville Road		10f. Zip Code 20901		10g. Citizen of What Country? USA	
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 2 College (1-4or 5+) 2		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Mechanical Designer		16b. Kind of Business/Industry Medical Instrument Design	
17. Father's Name (First, Middle, Last) Thomas Perone			18. Mother's Name (First, Middle, Maiden Surname) Elizabeth Stiel		
19a. Informant's Name/Relationship (Type, Print) Carole A. Slenkovich/ Daughter		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9518 Biltmore Drive, Silver Spring, MD 20901			
20a. Method of Disposition <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input checked="" type="checkbox"/> Donation <input checked="" type="checkbox"/> Other (Specify) Entombment		20b. Place of Disposition (Name of cemetery, crematory or other place) Gate of Heaven Cemetery		20c. Location - City or Town, State January 22 2004 Silver Spring, MD	
21. Signature of Funeral Service Licensee 		22. Name and Address of Facility Francis J. Collins Funeral Home Inc. 500 University Blvd. W., Silver Spring, MD 20901			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Heart Failure Due to (or as a consequence of): Coronary Artery Disease Due to (or as a consequence of): Prostate Carcinoma with Metastases, Anemia, Renal Insufficiency, Stroke (July 26, 2003)					
23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown					
23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify)					
23d. Date of delivery Month Day Year					
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Prostate Carcinoma with Metastases, Anemia, Renal Insufficiency, Stroke (July 26, 2003)					
23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown					
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M	
28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred			
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.					
29b. Signature and title of certifier 		29c. License number D08188		29d. Date signed (Month, Day, Year) January 19, 2004	
30. Name and address of person who completed cause of death (Item 29a) (Type, Print) Hugo Graziani M.D. 717 Pershing Drive, Silver Spring, MD 20910					
31. Date filed (Month, Day, Year) JAN 21 2004		32. Registrar's Signature 			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.



State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2004 03925

1- For
State
RegistrarPhysician
/Medical
ExaminerFuneral
Director

1. Decedent's Name (First, Middle, Last) Rocco Anthony Panetta				2. Date of Death Month Day Year January 20, 2004		3. Time of Death 12:20 aM	
4a. Facility Name (If not institution, give street and number) Montgomery General Hospital				4b. City, Town, or Location of Death Olney		4c. County of Death Montgomery	
5. Social Security Number 577-38-0696		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 84 Yrs.		8. Date of Birth (Month, Day, Year) July 31, 1919	
9. Birthplace (State or Foreign Country) Washington, DC							
Usual Residence of Decedent							
10a. State Maryland		10b. County Montgomery		10c. City, Town or Location Silver Spring		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
10e. Street and Number 3340 Chiswick Court				10f. Zip Code 20906		10g. Citizen of What Country? USA	
11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: WWII		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Manager		16b. Kind of Business/Industry Hotel	
17. Father's Name (First, Middle, Last) Gabriel Panetta				18. Mother's Name (First, Middle, Maiden Surname) Teresa Scagnelli			
19a. Informant's Name/Relationship (Type, Print) Elizabeth L. Panetta/Sister				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3340 Chiswick Court, Silver Spring, MD 20906			
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Fort Lincoln Cemetery		Date January 24, 2004		20c. Location - City or Town, State Brentwood, Maryland	
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility Francis J. Collins Funeral Home Inc. 500 University Blvd. W., Silver Spring, MD 20901			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Pneumonia Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last							
Approximate Interval Between Onset and Death 24 hours							
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <input type="checkbox"/> Unknown				23d. Date of delivery Month Day Year	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Congestive Heart Failure, Cardiomyopathy						23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown	
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No					
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28d. Describe how injury occurred			
28f. Location (Street and Number or Rural Route Number, City or Town, State)							
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.							
29b. Signature and title of certifier 				29c. License number D24543		29d. Date signed (Month, Day, Year) January 20, 2004	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) James A. Rossi M.D. 3305 North Leisure World Blvd., Silver Spring, MD 20906							
31. Date filed (Month, Day, Year) JAN 21 2004				32. Registrar's Signature 			

To Be Completed by Funeral Director

Medical Certification; To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

5+1

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2004 03926

Physician
/Medical
Examiner

Funeral
Director

1. Decedent's Name (First, Middle, Last)

RUTH MATHEW PHIPPS

2. Date of Death

Month Day Year
FEB. 3, 2004

3. Time of Death

7:05 P.M.

4a. Facility Name (If not institution, give street and number)

CHARLES CO. NURSING & REHAB. CENTER

4b. City, Town, or Location of Death

LA PLATA

4c. County of Death

CHARLES

5. Social Security Number

229-16-3604

6. Sex

☐ M ☒ F

7. Age (In yrs. last birthday)

82 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
SEPT. 9, 1920

9. Birthplace (State or Foreign Country)

VIRGINIA

Usual Residence of Decedent

10a. State

MARYLAND

10b. County

CHARLES

10c. City, Town or Location

LA PLATA

10d. Inside City Limits

☒ Yes ☐ No

10e. Street and Number

10200 LA PLATA ROAD

10f. Zip Code

20646

10g. Citizen of What Country?

U.S.A.

11. Marital Status

☐ Never Married ☐ Married

☒ Widowed ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

☐ Yes ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

☐ Yes ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (14 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

HOMEMAKER

16b. Kind of Business/Industry

OWN HOME

17. Father's Name (First, Middle, Last)

BENJAMIN FOLEY MATHEW

18. Mother's Name (First, Middle, Maiden Surname)

IVA DORA ANDERSON

19a. Informant's Name/Relationship (Type, Print)

THOMAS A. PHIPPS-SON

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

38228 GOLDEN BEACH RD. MECHANICSVILLE, MD. 20659

20a. Method of Disposition

☒ Burial ☐ Cremation ☐ Removal from State

☐ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

SUDLEY METH. CHURCH CEM. 2-6-04 MANASSASS, VA.

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

M00479

22. Name and Address of Facility

RAYMOND FUNERAL SERVICE, P.A.

LA PLATA, MARYLAND 20646

23e. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. *Pneumonia*
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death
7:05 PM
2/03/04

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☒ No ☐ Probably ☐ Unknown

24a. Was an autopsy performed?

☐ Yes ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

☐ Yes ☒ No

25. Was case referred to medical examiner?

☐ Yes ☒ No

Hospital: ☐ Inpatient ☐ ER/Outpatient ☐ DOA

Other: ☒ Nursing Home ☐ Residence ☐ Other (Specify)

27. Manner of Death

☒ Natural ☐ Pending investigation
☐ Accident ☐ Suicide ☐ Homicide
☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

☐ Yes ☒ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Michael Leatherwood 4.D. 12079 Old Line Ctr #202
Waldorf MD 20602

31. Date filed (Month, Day, Year)

FEB 10 2004

32. Registrar's Signature

[Signature]

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2004 03927

1- For
State
Registrar

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Columbia D. Pontorno		2. Date of Death Month Day Year 01/17/2004		3. Time of Death 9:05 A M
	4a. Facility Name (If not institution, give street and number) Bradford Oaks Nursing Home		4b. City, Town, or Location of Death Clinton		4c. County of Death Prince George's
Funeral Director	5. Social Security Number 578-12-7946	6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 89 Yrs.	8. Date of Birth (Month, Day, Year) 09/06/1914	9. Birthplace (State or Foreign Country) Washington, DC
	Usual Residence of Decedent				
To Be Completed by Funeral Director	10a. State Maryland	10b. County Charles	10c. City, Town or Location Waldorf		10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
	10e. Street and Number 774 University Drive		10f. Zip Code 20602		10g. Citizen of What Country? USA
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:
	14. Race - American Indian, Black, White, etc. Specify: White		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 2 College (1-4 or 5+)		
	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Secretary		16b. Kind of Business/Industry Federal Government		
	17. Father's Name (First, Middle, Last) Gervasio Mazzucco		18. Mother's Name (First, Middle, Maiden Surname) Maria Vallario		
	19a. Informant's Name/Relationship (Type, Print) Jim Pontorno / Son		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 774 University Dr. Waldorf, Maryland 20602		
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Resurrection Cem.		20c. Location - City or Town, State Clinton, Maryland
	21. Signature of Funeral Service Licensee <i>George P. Kalas</i>		22. Name and Address of Facility George P. Kalas Funeral Home P.A. 6160 Oxon Hill Road Oxon Hill, Maryland 20745		
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. <u>INFLUENZA</u> Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last				
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 9 <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) 9 <input type="checkbox"/> Unknown		23d. Date of delivery Month Day Year	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>Alzheimer's Disease</u>				23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown	
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No			
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M	
28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred		28e. Location (Street and Number or Rural Route Number, City or Town, State)	
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.					
29b. Signature and title of certifier <i>William T. Tanner M.D.</i>		29c. License number D35206		29d. Date signed (Month, Day, Year) January 19, 2004	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) William T. TANNER M.D. 1170 L Livingston Road, Fort Washington, Maryland					
31. Date filed (Month, Day, Year) JAN 20 2004		32. Registrar's Signature <i>John A. Smith</i>			

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23e or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2004 03928

1- For
State
RegistrarPhysician
/Medical
ExaminerFuneral
Director

1. Decedent's Name (First, Middle, Last)

Robert Scott Parks

2. Date of Death

January 16 2004

3. Time of Death

8:05p^M

4a. Facility Name (If not institution, give street and number)

Doctors Hospital

4b. City, Town, or Location of Death

Lanham

4c. County of Death

Prince Georges

5. Social Security Number

236-11-1352

6. Sex

1^M 2^F

7. Age (In yrs. last birthday)

41

Yrs.

If Under 1 Year

Months

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

10/31/62

9. Birthplace (State or Foreign Country)

Virginia

Usual Residence of Decedent

10a. State

MD

10b. County

Prince Georges

10c. City, Town or Location

Bowie

10d. Inside City Limits

1^{Yes} 2^{No}

10e. Street and Number

10417 Vista Gardens Drive

10f. Zip Code

20720

10g. Citizen of What Country?

USA

11. Marital Status

1^{Never Married} 2^{Married}
3^{Widowed} 4^{Divorced}

12. Was Decedent Ever in U.S.

1^{Yes} 2^{No}
If Yes, Give
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1^{Yes} 2^{No} Specify:14. Race - American Indian,
Black, White, etc.

Specify: black

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4or 5+)

4

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)Manager
Business Developing

16b. Kind of Business/Industry

Academy Ford

17. Father's Name (First, Middle, Last)

Charles Raymond Parks

18. Mother's Name (First, Middle, Maiden Surname)

Bernice Grantham

19a. Informant's Name/Relationship (Type, Print)

Barbara Parks/wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

10417 Vista Gardens Dr. Bowie, MD 20720

20a. Method of Disposition

1^{Burial} 2^{Cremation} 3^{Removal from State}
4^{Donation} 5^{Other (Specify)}20b. Place of Disposition (Name of
cemetery, crematory or other place)

Glenwood Cemetery

Date

1/23/04

20c. Location - City or Town, State

Washington DC

21. Signature of Funeral Service Licensee

Lisa A. Henry

22. Name and Address of Facility

B K Henry Funeral Chapel Inc.
420 H Street NE Washington DC 2000223a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

Acute Pancreatitis

Due to (or as a consequence of):
Septic ShockSequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) LastDue to (or as a consequence of):
metabolic acidosisDue to (or as a consequence of):
Acute renal failureApproximate
Interval Between
Onset and Death

IF FEMALE:

23b. Was decedent pregnant

1^{Yes} 2^{No}
3^{Unknown}

23c. If yes, outcome of pregnancy

1^{Live birth} 2^{Fetal death} 3^{Ectopic pregnancy}
4^{Pregnant at time of death} 5^{Other (specify)}
9^{Unknown}

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Human Immunodeficiency Virus
Respiratory failure
Pneumonia

23e. Did tobacco use contribute to the cause of death?

1^{Yes} 2^{No} 3^{Probably} 4^{Unknown}24a. Was an
autopsy
performed?1^{Yes} 2^{No}24b. Were autopsy findings available
prior to completion of cause of
death?1^{Yes} 2^{No}25. Was case referred to medical
examiner?1^{Yes} 2^{No}

26. Place of Death (Check only one)

Hospital: 1^{Inpatient} 2^{ER/Outpatient} 3^{DOA} Other: 4^{Nursing Home} 5^{Residence} 6^{Other (Specify)}

27. Manner of Death

1^{Natural} 2^{Accident} 3^{Suicide} 4^{Homicide}
5^{Pending investigation} 6^{Could not be determined}

28a. Date of Injury

(Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1^{Yes} 2^{No}

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only one)1^{Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.}
2^{Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.}

29b. Signature and Title of certifier

Dr. [Signature]

29c. License number

D58446

29d. Date signed (Month, Day, Year)

1/19/2004

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Nadezhda Kovalevskaya, MD 8118 Good Luck Lanham, Maryland 20706

31. Date filed (Month, Day, Year)

JAN 23 2004

32. Registrar's Signature

[Signature]

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

CP (5)

State
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2004 03929

1- For
State
Registrar

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Physician
/Medical
ExaminerFuneral
Director

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

1. Decedent's Name (First, Middle, Last) IDA B. ROSENHEIM		2. Date of Death Month JANUARY Day 20 Year 2004		3. Time of Death 9:50 AM	
4a. Facility Name (If not institution, give street and number) SHADY GROVE ADVENTIST HOSPITAL		4b. City, Town, or Location of Death ROCKVILLE		4c. County of Death MONTGOMERY	
5. Social Security Number 579-20-0959	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 80 Yrs.	8. Date of Birth (Month, Day, Year) FEB. 20, 1923		9. Birthplace (State or Foreign Country) WASHINGTON, DC
Usual Residence of Decedent					
10a. State MARYLAND	10b. County MONTGOMERY	10c. City, Town or Location SILVER SPRING		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
10e. Street and Number 816 MALTA LANE		10f. Zip Code 20901		10g. Citizen of What Country? UNITED STATES OF AMERICA	
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:	
14. Race - American Indian, Black, White, etc. Specify: WHITE		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 2 College (1-4 or 5+) 2			
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) EDITOR		16b. Kind of Business/Industry UNITED STATES GENERAL ACCOUNTING OFFICE			
17. Father's Name (First, Middle, Last) ISADORE KATZMAN			18. Mother's Name (First, Middle, Maiden Surname) NELLIE SHUSTER		
19a. Informant's Name/Relationship (Type, Print) SIDNEY ROSENHEIM - HUSBAND		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 816 MALTA LANE, SILVER SPRING, MD 20901			
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) JUDEAN MEMORIAL GARDEN		20c. Location - City or Town, State OLNEY, MARYLAND	
21. Signature of Funeral Service Licensee Donald C. Stettinmeyer		22. Name and Address of Facility DANZANSKY GOLDBERG MEMORIAL CHAPEL, INC 1170 ROCKVILLE PIKE, ROCKVILLE, MD 20852			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last					Approximate Interval Between Onset and Death
a. HYPERTENSIVE HEART DISEASE Due to (or as a consequence of): b. CEREBROVASCULAR ACCIDENT Due to (or as a consequence of): c. PNEUMONIA Due to (or as a consequence of): d. ALZHEIMERS'S DEMENTIA Due to (or as a consequence of):					
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Unknown		23d. Date of delivery Month Day Year	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ACUTE RENAL FAILURE					23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M	
		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred	
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)	
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.					
29b. Signature and title of certifier Thomas V. Joseph		29c. License number D47330		29d. Date signed (Month, Day, Year) JANUARY 20, 2004	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) THOMAS V. JOSEPH, MD, 50 WEST EDMONSTON DRIVE, ROCKVILLE, MD 20852					
31. Date filed (Month, Day, Year) JAN 22 2004		32. Registrar's Signature Sparks			

State
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2004 03930

1- For State Registrar

Physician /Medical Examiner

Funeral Director

1. Decedent's Name (First, Middle, Last) Sharon D. Roark		2. Date of Death Month: January Day: 21 Year: 2004		3. Time of Death 1:45 P M
4a. Facility Name (If not institution, give street and number) 12301 Tree Top Drive #44		4b. City, Town, or Location of Death Silver Spring		4c. County of Death Montgomery
5. Social Security Number 415-86-9304	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 52 Yrs.	8. Date of Birth (Month, Day, Year) Dec. 14, 1951	9. Birthplace (State or Foreign Country) Tennessee
Usual Residence of Decedent				
10a. State Md.	10b. County Montgomery	10c. City, Town or Location Silver Spring		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
10e. Street and Number 12301 Tree Top Drive #44		10f. Zip Code 20904		10g. Citizen of What Country? United States
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No 1977 If Yes, Give Year or Dates: to 1980		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:
14. Race - American Indian, Black, White, etc. Specify: White		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 2 College (1-4 or 5+)		
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Nurse		16b. Kind of Business/Industry Nursing		
17. Father's Name (First, Middle, Last) Robert Earl Hughes		18. Mother's Name (First, Middle, Maiden Surname) Bertha Mae Tipton		
19a. Informant's Name/Relationship (Type, Print) Shannon Koutavas (Daughter)		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4003 Wedge Court Mt. Airy, Md. 21771		
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Metropolitan Crem.		20c. Location - City or Town, State Alexandria, Va.
21. Signature of Funeral Service Licensee Curtis E. Day		22. Name and Address of Facility DeVol Funeral Home 10 East Deer Park Dr. Gaithersburg, Md. 20877		
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. ASCVD Due to (or as a consequence of): b. DME Due to (or as a consequence of): c. Due to (or as a consequence of): d.				
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown 23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <input type="checkbox"/> Unknown 23d. Date of delivery Month Day Year				
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				
23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown				
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No				
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)				
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No 28d. Describe how injury occurred 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier IRAN BRECHER MD 29c. License number 100728 29d. Date signed (Month, Day, Year) Jan 22 2004				
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) IRAN BRECHER MD 2101 Medical Park Dr Silver Spring MD 20902				
31. Date filed (Month, Day, Year) JAN 23 2004 32. Registrar's Signature Sparks				

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2004 03931

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Patricia Anne Reidenbaugh

2. Date of Death
Month Day Year

January 19, 2004 8:15 AM

3. Time of Death

Funeral
Director

4a. Facility Name (If not institution, give street and number)

Hebrew Home of Greater Washington

4b. City, Town, or Location of Death

Rockville

4c. County of Death

Montgomery

5. Social Security Number

188-24-3755

6. Sex

☐ M ☒ F

7. Age (In yrs. last birthday)

72

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth
(Month, Day, Year)

May 18, 1931

9. Birthplace (State or Foreign Country)

Pennsylvania

Usual Residence of Decedent

10a. State

Virginia

10b. County

Fairfax

10c. City, Town or Location

McLean

10d. Inside City Limits

☐ Yes ☒ No

10e. Street and Number

1504 Lincoln Way #204

10f. Zip Code

22102

10g. Citizen of What Country?

USA

11. Marital Status

☐ Never Married ☐ Married☒ Widowed ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

☐ Yes ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

☐ Yes ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Office Manager

16b. Kind of Business/Industry

Real Estate

17. Father's Name (First, Middle, Last)

Willard Crist

18. Mother's Name (First, Middle, Maiden Surname)

Claudia Rokosky

19a. Informant's Name/Relationship (Type, Print)

James Andrew Reidenbaugh/Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1555 Sunstone Dr., McLean, Va. 22102

20a. Method of Disposition

☐ Burial ☒ Cremation ☐ Removal from State☐ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Metropolitan Crematory

Date

1/27/04

20c. Location - City or Town, State

Alexandria, Va.

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

MONEY & KING FUNERAL HOME, INC.

171 W. Maple Ave., Vienna, Va. 22180

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. MYOCARDIAL INFARCTION

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☒ No ☐ Probably ☒ Unknown

24a. Was an autopsy performed?

☐ Yes ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

☐ Yes ☒ No

25. Was case referred to medical examiner?

☐ Yes ☒ No

Hospital:

☐ Inpatient ☐ ER/Outpatient ☐ DOA

Other:

☒ Nursing Home ☐ Residence ☐ Other (Specify)

27. Manner of Death

☒ Natural☐ Accident☐ Suicide☐ Homicide☐ Pending investigation☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

☐ Yes ☒ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number

D24942

29d. Date signed (Month, Day, Year)

JAN 19 2004

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

GREGORY A. COMPTON MD 6121 Montrose Rd Rockville, MD

31. Date filed (Month, Day, Year)

JAN 23 2004

32. Registrar's Signature

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
ExaminerTo the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

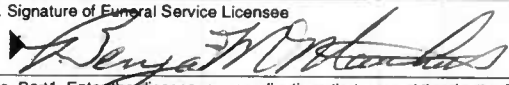
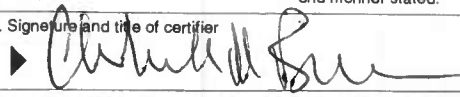

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2004 03932

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) RACHEL RAE RAWSON				2. Date of Death Month JANUARY Day 19 Year 2004		3. Time of Death 2:55P.M.		
	4a. Facility Name (If not institution, give street and number) Hillhaven Assisted Living Nursing & Rehab Center				4b. City, Town, or Location of Death Adelphi		4c. County of Death Prince George's		
Funeral Director	5. Social Security Number 063-01-6282		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 91 Yrs.		8. Date of Birth (Month, Day, Year) Sept. 16, 1912		
	9. Birthplace (State or Foreign Country) Oklahoma		10a. State Maryland		10b. County Montgomery		10c. City, Town or Location Silver Spring		
Usual Residence of Decedent		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		10e. Street and Number 10404 Royal Road		10f. Zip Code 20903		10g. Citizen of What Country? United States	
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12		College (14 or 5+) 1-4		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Broker		16b. Kind of Business/Industry Real Estate			
17. Father's Name (First, Middle, Last) Robison				18. Mother's Name (First, Middle, Maiden Surname) unk					
19a. Informant's Name/Relationship (Type, Print) James Rawson -son				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10404 Royal Road Silver Spring, Maryland 20903					
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Metropolitan Crematory		Date 1/20/2004		20c. Location - City or Town, State Alexandria, Virginia			
21. Signature of Funeral Service Licensee 		22. Name and Address of Facility Donald V. Borgwardt Funeral Home, P.A. 4400 Powder Mill Rd. Beltsville, Maryland 20705							
23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or organ failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Atherosclerotic Cardiovascular Disease		Due to (or as a consequence of):				Approximate Interval Between Onset and Death 20 years			
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of):									
c. Due to (or as a consequence of):									
d. Due to (or as a consequence of):									
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Diabetes Mellitus				23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown					
				24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No			
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		28d. Describe how injury occurred	
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier 		29c. License number D31563		29d. Date signed (Month, Day, Year) January 20, 2004			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Charles Benner, M.D. 10801 Lockwood Drive, #205 Silver Spring, Maryland 20901									
31. Date filed (Month, Day, Year) JAN 21 2004		32. Registrar's Signature 							

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2004 03933

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

JERRY VINCENT RASO

2. Date of Death

January 12, 2004

3. Time of Death

8:12 AM

4a. Facility Name (If not institution, give street and number)

Shady Grove Adventist Hospital

4b. City, Town, or Location of Death

Rockville

4c. County of Death

Montgomery

Funeral
Director

5. Social Security Number

131-14-6379

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

79 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
Sept. 6, 1924

9. Birthplace (State or Foreign Country)

New York

Usual Residence of Decedent

10a. State

Md.

10b. County

Montgomery

10c. City, Town or Location

Gaithersburg

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

720 Quince Orchard Blvd. #T2

10f. Zip Code

20878

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)
12

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Proof Reader

16b. Kind of Business/Industry

Government Printing Office

17. Father's Name (First, Middle, Last)

John Raso

18. Mother's Name (First, Middle, Maiden Surname)

Jennie Murano

19a. Informant's Name/Relationship (Type, Print)

Marilyn S. Raso (Wife)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

720 Quince Orchard Blvd. #T2 Gaithersburg, Md. 20878

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Metropolitan Crematory

Date

Jan. 12, 2004

20c. Location - City or Town, State

Alexandria, Virginia

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

DeVol Funeral Home
10 East Deer Park Dr. Gaithersburg, Md. 20877

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Sepsis

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Days

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Peritonitis

Due to (or as a consequence of):

Days

c.

Due to (or as a consequence of):

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Recent hemicolectomy for diverticular bleeding,
coronary disease with recent M.I., renal failure
on dialysis, COPD

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural
2 ☐ Accident
3 ☐ Suicide
4 ☐ Homicide
5 ☐ Pending investigation
6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

☒ Certifying Physician☐ Medical Examiner

To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

29453

29d. Date signed (Month, Day, Year)

January 14, 2004

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MARIA CITANAVEY 15115 Shady Grove Rd Rockville MD 20850

31. Date filed (Month, Day, Year)

JAN 20 2004

32. Registrar's Signature

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

1- For
State
Registrar

2004 03934

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permal. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-e show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Physician
/Medical
ExaminerFuneral
Director

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

1. Decedent's Name (First, Middle, Last) Chanderdase Ragbir				2. Date of Death Month JAN. Day 16, Year 2004		3. Time of Death 6:30 A^M	
4a. Facility Name (If not institution, give street and number) HOLY CROSS HOSPITAL				4b. City, Town, or Location of Death SILVER SPRING		4c. County of Death MONTGOMERY	
5. Social Security Number 580-02-5770		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 75 Yrs.	8. Date of Birth (Month, Day, Year) JAN. 25, 1928		9. Birthplace (State or Foreign Country) TRINIDAD	
Usual Residence of Decedent							
10a. State MD.		10b. County PRINCE GEORGES		10c. City, Town or Location BELTSVILLE		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
10e. Street and Number 12504 CALVERT HILLS DR.				10f. Zip Code 20705		10g. Citizen of What Country? U.S.A.	
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: WEST INDIAN	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 8 College (1-4 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) HOUSEWIFE		16b. Kind of Business/Industry AT HOME	
17. Father's Name (First, Middle, Last) BALKISSOON GOCOOL				18. Mother's Name (First, Middle, Maiden Surname) RAMPIARI RAMHARRACK			
19a. Informant's Name/Relationship (Type, Print) NAITHRAM RAGBIR/HUSBAND				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12504 CALVERT HILLS DR., BELTSVILLE, MD. 20705			
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) CHAMBERS CREMATORY		Date 1-19-2004		20c. Location - City or Town, State RIVERDALE, MD.	
21. Signature of Funeral Service Licensee W.W. Chambers M00091				22. Name and Address of Facility CHAMBERS FUNERAL HOME & CREMATORIUM, P.A. 5801 CLEVELAND AVE., RIVERDALE, MD. 20737			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) asystole Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last staphylococcal bacteremia							
23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown							
23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <input type="checkbox"/> Unknown							
23d. Date of delivery Month Day Year							
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. chronic renal failure							
23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown							
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No							
26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
28d. Describe how injury occurred						28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	
28f. Location (Street and Number or Rural Route Number, City or Town, State)							
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.							
29b. Signature and title of certifier Chanderdase Ragbir				29c. License number D20700		29d. Date signed (Month, Day, Year) 1/16/04	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MARK ROSEN, M.D. 15225 SHADY GROVE RD. #206, ROCKVILLE, MD. 20850							
31. Date filed (Month, Day, Year) JAN 20 2004				32. Registrar's Signature Bruce S. Sparks			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2004 03935

1- For
State
RegistrarPhysician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Philip Stephen Rados

2. Date of Death

January 15 2004

3. Time of Death

1:10 A M

Funeral
Director

4a. Facility Name (If not institution, give street and number)

Shady Grove Adventist Hospital

4b. City, Town, or Location of Death

Rockville

4c. County of Death

Montgomery

5. Social Security Number

578-09-8738

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

84 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Aug. 31, 1919

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Derwood

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

7713 Yellowstone Way

10f. Zip Code

20855

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☒ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☒ Yes 2 ☐ No

If Yes, Give

Year or Dates: 1942-

1946

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: White

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

2

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

Mail Clerk

16b. Kind of Business/Industry

Newspaper

17. Father's Name (First, Middle, Last)

Stephen George Rados

19a. Informant's Name/Relationship (Type, Print)

Patricia D. Rados / Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

7713 Yellowstone Way Derwood, Maryland 20855

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Date

Jan. 15,

Metropolitan Crematory 2004

20c. Location - City or Town, State

Alexandria, Virginia

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

DeVol Funeral Home

10 E. Deer Park Dr. Gaithersburg, MD 20877

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,

shock, or heart failure. List only one cause on each line.

Immediate Cause (Final

disease or condition

resulting in death)

a. Myocardial infarction

Due to (or as a consequence of):

b. Lung Cancer

Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Sequentially list conditions,

if any, leading to immediate

cause. Enter Underlying

Cause (Disease or injury

that initiated events

resulting in death) Last

IF FEMALE:

23b. Was decedent pregnant

in the past 12 months?

1 ☐ Yes 2 ☐ No9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death3 ☐ Ectopic pregnancy4 ☐ Pregnant at time of death5 ☐ Other (specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an

autopsy

performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available

prior to completion of cause of

death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical

examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient2 ☒ Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending

investigation

6 ☐ Could not be

determined

28a. Date of Injury

(Month, Day Year)

28b. Time of

Injury

M

28c. Injury at

Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office

building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number,

City or Town, State)

29a. Certifier

(Check only

one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

and manner stated.

29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year)

January 15, 2004

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Deborah J. Schmill Mrs 9901 Medical Center Dr Rockville, MD 20855

31. Date filed (Month, Day, Year)

JAN 20 2004

32. Registrar's Signature

Sparks

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To Be Completed by Funeral Director

Medical Certification; To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

State
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2004 03936

1- For
State
Registrar

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Denzil Ruth Ramey						2. Date of Death Month Day Year January 22, 2004		3. Time of Death 10:56 P M	
	4a. Facility Name (If not institution, give street and number) St. Mary's Hospital						4b. City, Town, or Location of Death Leonardtwn		4c. County of Death St. Mary's	
Funeral Director	5. Social Security Number 509-18-2152		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 84 Yrs.		8. Date of Birth (Month, Day, Year) January 1, 1920		9. Birthplace (State or Foreign Country) Kansas	
	Usual Residence of Decedent									
To Be Completed by Funeral Director	10a. State Kansas		10b. County Sumner		10c. City, Town or Location Wellington				10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No	
	10e. Street and Number 400 S. "C" Street #312				10f. Zip Code 67152		10g. Citizen of What Country? USA			
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Bank Clerk			16b. Kind of Business/Industry Banking		
	17. Father's Name (First, Middle, Last) Gilbert Howard McCammon						18. Mother's Name (First, Middle, Maiden Surname) Mary Etta Howard			
	19a. Informant's Name/Relationship (Type, Print) Andrea Day/Daughter						19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 723 W. 20th Street, Wellington, KS 67152			
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Osborne Cemetery		Date 01/30/2004		20c. Location - City or Town, State Mayfield, Kansas	
	21. Signature of Funeral Service Licensee 						22. Name and Address of Facility Mattingley-Gardiner Funeral Home, P.A. P.O. Box 270 Leonardtown, MD 20650			
	23a. Part I: Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Acute myocardial infarct Due to (or as a consequence of): b. Acute pulmonary embolus Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last									
	23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 9 <input type="checkbox"/> Unknown									
23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) 9 <input type="checkbox"/> Unknown										
23d. Date of delivery Month Day Year										
To Be Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Renal Insufficiency Congestive Heart Failure									
	23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown									
	24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No					24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No				
	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No					26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)				
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined					28a. Date of Injury (Month, Day Year) M				
	28b. Time of Injury M					28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No				
	28d. Describe how injury occurred					28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				
	28f. Location (Street and Number or Rural Route Number, City or Town, State)					28g. Location (Street and Number or Rural Route Number, City or Town, State)				
	29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.									
	29b. Signature and title of certifier 					29c. License number D56096				
29d. Date signed (Month, Day, Year) January 23, 2004					30. Name and address of person who completed cause of death (Item 23a) (Type, Print) RAEBINDER S. GILL SHAN ASSOCIATES HOLLYWOOD MD 20626					
State Registrar	31. Date filed (Month, Day, Year) FEB 03 2004					32. Registrar's Signature 				

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2004 03937

1- For State Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Estiss Eugene Reedy				2. Date of Death Month Day Year January 30 2004		3. Time of Death 1344 P M	
	4a. Facility Name (If not institution, give street and number) Union Hospital				4b. City, Town, or Location of Death Elkton		4c. County of Death Cecil	
Funeral Director	5. Social Security Number 224-44-2487		6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		7. Age (In yrs. last birthday) 63 Yrs.		8. Date of Birth (Month, Day, Year) May 25, 1940	
	9. Birthplace (State or Foreign Country) Virginia		10a. State Maryland		10b. County Cecil		10c. City, Town or Location Elkton	
To Be Completed by Funeral Director	10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		10e. Street and Number 652 Frenchtown Road		10f. Zip Code 21921		10g. Citizen of What Country? United States	
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates: 1956 to 1957		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4or 5+) 12		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Production		16b. Kind of Business/Industry Plastic Manufacturing			
	17. Father's Name (First, Middle, Last) Walter Lee Reedy				18. Mother's Name (First, Middle, Maiden Surname) Idabelle Dye			
	19a. Informant's Name/Relationship (Type, Print) Bertha M. Reedy/Wife				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 652 Frenchtown Road, Elkton, Maryland 21921			
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Gilpin Manor Memorial Park		Date February 4, 2004		20c. Location - City or Town, State Elkton, Maryland	
	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility Hicks Home for Funerals, P.A. 103 W. Stockton Street, Elkton, Maryland 21921			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Myocardial infarction Due to (or as a consequence of): b. Severe ischemic cardiomyopathy Due to (or as a consequence of): c. Atherosclerotic Coronary Artery Disease Due to (or as a consequence of): d. Approximate Interval Between Onset and Death 1 hour years years							
	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 4 <input type="checkbox"/> Pregnant at time of death 9 <input type="checkbox"/> Unknown 3 <input type="checkbox"/> Ectopic pregnancy 5 <input type="checkbox"/> Other (specify)				23d. Date of delivery Month Day Year	
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Hypertension Diabetes						23e. Did tobacco use contribute to the cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown	
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)						
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28d. Describe how injury occurred				
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier 		29c. License number 245755		29d. Date signed (Month, Day, Year) 01/30/2004		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) John R. Mulvey, M.D., 111 West High Street, Suite 314, Elkton, Maryland 21921								
31. Date filed (Month, Day, Year) FEB 10 2004		32. Registrar's Signature 						

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- Amend Item #1,4c

Undepend Item #23a-b, 27, 28a-1, Per ME, 6828, 3/4/04

Certificate of Death

Reg. No.

2004 03938

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Ezorion Juan Randolph

2. Date of Death

JAN. 22, 2004

3. Time of Death

0959 A M

Funeral
Director

4a. Facility Name (If not institution, give street and number)

WASHINGTON ADVENTIST HOSPITAL

4b. City, Town, or Location of Death

TAKOMA PARK

4c. County of Death

MONTGOMERY

5. Social Security Number

212-69-2572

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

11/30/03

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

MD

10b. County

Prince George's

10c. City, Town or Location

College Park

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

4716 Lakeland Rd.

10f. Zip Code

20740

10g. Citizen of What Country?

USA

11. Marital Status

1 ☒ Never Married 2 ☐ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

N/A

College (1-4or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

N/A

16b. Kind of Business/Industry

N/A

17. Father's Name (First, Middle, Last)

Joshua Johnson

18. Mother's Name (First, Middle, Maiden Surname)

Ebony Randolph

19a. Informant's Name/Relationship (Type, Print)

PatriceJewell/ Aunt

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

3839 64th Ave. #310 Hyattsville, MD 20784

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Maryland National

Date

1/31/04

20c. Location - City or Town, State

Laurel, MD

21. Signature of Funeral Service Licensee

K. D. Marshall

22. Name and Address of Facility

J.B. Jenkins Funeral Home

7474 Landover Rd. Landover, MD 20785

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Asphyxia

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Overlay

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Due to (or as a consequence of):

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☐ No3 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death4 ☐ Pregnant at time of death9 ☐ Unknown3 ☐ Ectopic pregnancy5 ☐ Other (specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☒ Yes 2 ☐ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☒ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☒ Yes 2 ☐ No

Hospital:

1 ☐ Inpatient 2 ☒ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury

found 1/22/04

28b. Time of Injury

found 9:00 a

28c. Injury at Work?

1 ☐ Yes 2 ☒ No

28d. Describe how injury occurred

co-sleeping with adult

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

found at home

28f. Location (Street and Number or Rural Route Number, City or Town, State)

4716 Lakeland Road, College Park, Maryland

29a. Certifier (Check only one)

1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Tasha Z Greenberg MD

29c. License number

O.C.M.E

29d. Date signed (Month, Day, Year)

JAN. 24, 2004

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Tasha Z Greenberg MD 111 Penn Street, Baltimore, Maryland 21201

31. Date filed (Month, Day, Year)

JAN 28 2004

32. Registrar's Signature

K. D. Marshall

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2004 03939

1- For State Registrar

Physician /Medical Examiner
Funeral Director
To Be Completed by Funeral Director
To Be Completed by Physician/Medical Examiner
State Registrar

1. Decedent's Name (First, Middle, Last) Ruth J Swift		2. Date of Death Month 1 Day 21 Year 2004/2005 M		3. Time of Death M	
4a. Facility Name (If not institution, give street and number) Howard County General Hospital		4b. City, Town, or Location of Death Columbia		4c. County of Death Howard	
5. Social Security Number 579-09-7161	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 88 Yrs.	8. Date of Birth (Month, Day, Year) Aug. 27, 1915	9. Birthplace (State or Foreign Country) West Virginia	
Usual Residence of Decedent		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
10a. State Maryland	10b. County Montgomery	10c. City, Town or Location Rockville			
10e. Street and Number 16201 Grist Mill Drive		10f. Zip Code 20855		10g. Citizen of What Country? USA	
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 1 College (1-4or 5+) 1		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Clerical		16b. Kind of Business/Industry U.S. Government	
17. Father's Name (First, Middle, Last) Jesse Mustain Jennings		18. Mother's Name (First, Middle, Maiden Sumame) Nellie Hubble			
19a. Informant's Name/Relationship (Type, Print) Arnold Critzer/ Son		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 16201 Grist Mill Drive, Rockville, MD 20855			
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Parkland Memorial Park		20c. Location - City or Town, State Rockville, Maryland	
21. Signature of Funeral Service Licensee 		22. Name and Address of Facility Francis J. Collins Funeral Home Inc. 500 University Blvd. W., Silver Spring, MD 20901			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Pneumonia Due to (or as a consequence of): Pleural Effusions Due to (or as a consequence of): COPD Due to (or as a consequence of):					
23b. IF FEMALE: Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown					
23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <input type="checkbox"/> Unknown					
23d. Date of delivery Month Day Year					
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Diabetes Mellitus Coronary Heart Disease Seizures					
23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown					
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M	
		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred	
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)	
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.					
29b. Signature and title of certifier Kathleen York-Smith		29c. License number D37011		29d. Date signed (Month, Day, Year) 1-22-2004	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Kathleen YORK-Smith M.D. 9501 Old Annapolis Rd Elliot City MD 21042					
31. Date filed (Month, Day, Year) JAN 23 2004		32. Registrar's Signature 			

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

8

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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2004 03940

1- For State Registrar

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

10+1

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

1. Decedent's Name (First, Middle, Last) Morton T. Swarth		2. Date of Death Month January Day 20 , Year 2004		3. Time of Death 11:40 a M	
4a. Facility Name (If not institution, give street and number) Holy Cross Hospital		4b. City, Town, or Location of Death Silver Spring		4c. County of Death Montgomery	
5. Social Security Number 549-42-6009	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 83 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) Dec. 7, 1920
9. Birthplace (State or Foreign Country) California					
Usual Residence of Decedent					
10a. State California	10b. County Alameda	10c. City, Town or Location Oakland		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
10e. Street and Number 6850 Snake Road		10f. Zip Code 94611		10g. Citizen of What Country? USA	
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: 1940-49		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:	
14. Race - American Indian, Black, White, etc. Specify: White					
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 4 College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Engineer		16b. Kind of Business/Industry Engineering	
17. Father's Name (First, Middle, Last) Harry S. Swarth		18. Mother's Name (First, Middle, Maiden Surname) Winnifern Wood			
19a. Informant's Name/Relationship (Type, Print) Christopher Swarth/ Son		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1415 Crestridge Drive, Silver Spring, MD 20910			
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Metropolitan Crematory		20c. Location - City or Town, State Alexandria, Virginia	
21. Signature of Funeral Service Licensee 		22. Name and Address of Facility Francis J. Collins Funeral Home Inc. 500 University Blvd. W., Silver Spring, MD 20901			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Cardiopulmonary Arrest Due to (or as a consequence of): b. Cardiac Arrhythmia Due to (or as a consequence of): c. Hypotension Due to (or as a consequence of): d. Acute Blood Loss		Approximate Interval Between Onset and Death			
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <input type="checkbox"/> Unknown		23d. Date of delivery Month Day Year	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown	
				24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
				24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M	
		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred	
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)	
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.					
29b. Signature and title of certifier 		29c. License number 56147		29d. Date signed (Month/Day, Year) 1/20/04	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr. Nasreen Kango 7610 Carroll Avenue, #205, Takoma Park, MD 20912					
31. Date filed (Month, Day, Year) JAN 22 2004		32. Registrar's Signature 			

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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2004 03941

1- For
State
RegistrarPhysician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Shirley M. Snyder

2. Date of Death

January 16 2004

3. Time of Death

10:18 AM

4a. Facility Name (If not institution, give street and number)

Montgomery General Hospital

4b. City, Town, or Location of Death

Olney

4c. County of Death

Montgomery

5. Social Security Number

382-22-4524

6. Sex

1 ☐ M 2 ☒ F

7. Age (in yrs. last birthday)

76 Yrs.

If Under 1 Year

Months Days Hours Min.

8. Date of Birth

Mar. 8, 1927

9. Birthplace (State or Foreign Country)

Michigan

Usual Residence of Decedent

10a. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Gaithersburg

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

101 Odend Hal Avenue

10f. Zip Code

20877

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4or 5+)

12

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

Eugene N. Hannah, Sr.

18. Mother's Name (First, Middle, Maiden Surname)

Marcelene E. Krause

19a. Informant's Name/Relationship (Type, Print)

Mark R. Snyder / Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

5544 Wales Drive Eugene, Oregon 97402

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Norbeck Memorial Park

Date

Jan. 19, 2004

20c. Location - City or Town, State

Olney, Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

DeVol Funeral Home

10 E. Deer Park Dr. Gaithersburg, MD 20877

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. PNEUMONIA

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

14 DAYS

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. OBSTRUCTIVE LUNG DISEASE

Due to (or as a consequence of):

10 YEARS

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☒ No
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 5 ☐ Other (specify)
9 ☐ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy performed?
1 ☐ Yes 2 ☒ No24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☒ No25. Was case referred to medical examiner?
1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number

D23630

29d. Date signed (Month, Day, Year)

January 16, 2004

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Frank J. MAYO, MD 16226 Frederick RD #213, Gaithersburg, MD 20877

31. Date filed (Month, Day, Year)

JAN 20 2004

32. Registrar's Signature

State
Registrar

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2004 03942

1- For State Registrar

Physician /Medical Examiner

Funeral Director

1. Decedent's Name (First, Middle, Last) John Albert Smith		2. Date of Death Month January Day 14 Year 2004		3. Time of Death 1545 M	
4a. Facility Name (If not institution, give street and number) CENTER BROOKE GROVE REHABILITATION AND NURSING		4b. City, Town, or Location of Death SANDY SPRING		4c. County of Death MONTGOMERY	
5. Social Security Number 577-09-5015		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 84 Yrs.	
8. Date of Birth (Month, Day, Year) Oct. 1, 1919		9. Birthplace (State or Foreign Country) Washington, DC			
Usual Residence of Decedent					
10a. State Maryland		10b. County Montgomery		10c. City, Town or Location Silver Spring	
10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
10e. Street and Number 15011 Haslemere Court		10f. Zip Code 20906		10g. Citizen of What Country? USA	
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: WWII		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:	
14. Race - American Indian, Black, White, etc. Specify: White					
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Administrative Officer		16b. Kind of Business/Industry Federal Government	
17. Father's Name (First, Middle, Last) John A. Smith		18. Mother's Name (First, Middle, Maiden Surname) Jessie Myers			
19a. Informant's Name/Relationship (Type, Print) John A. Smith Son		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 114 Glencoe Road Upper Darby, Pennsylvania 19082			
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Gate of Heaven Cemetery		20c. Location - City or Town, State Jan. 19, 2004 Silver Spring, MD	
21. Signature of Funeral Service Licensee 		22. Name and Address of Facility Francis J. Collins Funeral Home, Inc. 500 University Blvd., W., Silver Spring, MD 20901			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. ASPIRATION PNEUMONIA Due to (or as a consequence of): b. DYSPHAGIA Due to (or as a consequence of): c. CEREBROVASCULAR ACCIDENT Due to (or as a consequence of): d.					
Approximate Interval Between Onset and Death DAYS DAYS 11 DAYS					
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <input type="checkbox"/> Unknown		23d. Date of delivery Month Day Year	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ALZHEIMER'S DISEASE				23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown	
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No			
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M	
28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		28d. Describe how injury occurred			
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.					
29b. Signature and title of certifier ATTENDING PHYSICIAN		29c. License number D42046		29d. Date signed (Month, Day, Year) JANUARY 14, 2004	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) GRACE BROOKE HUFFMAN, M.D. 18100 SHADE SCHOOL ROAD SANDY SPRING MARYLAND 20860					
31. Date filed (Month, Day, Year) JAN 20 2004		32. Registrar's Signature 			

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene
Certificate of Death

2004 03943

1- For State Registrar

Reg. No.

Physician / Medical Examiner	1. Decedent's Name (First, Middle, Last) SUSAN SOPOURN		2. Date of Death Month Day Year Jan. 17, 2004		3. Time of Death 6:50 P M
	4a. Facility Name (If not institution, give street and number) Shady Grove Hospital		4b. City, Town, or Location of Death Gaithersburg		4c. County of Death Montgomery
Funeral Director	5. Social Security Number 577-58-0146	6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 60 Yrs.	8. Date of Birth (Month, Day, Year) Nov. 12, 1943	9. Birthplace (State or Foreign Country) Wash. D.C.
	Usual Residence of Decedent				
To Be Completed by Funeral Director	10a. State Md.	10b. County Montgomery	10c. City, Town or Location Gaithersburg		10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No
	10e. Street and Number 9751 Brassie Way		10f. Zip Code 20886	10g. Citizen of What Country? U.S.A.	
To Be Completed by Physician/Medical Examiner	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:
	14. Race - American Indian, Black, White, etc. Specify: White		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4or 5+) 12		
To Be Completed by Physician/Medical Examiner	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Secretary		16b. Kind of Business/Industry International Assoc. of Fire Fighters		
	17. Father's Name (First, Middle, Last) Emery de Hartman		18. Mother's Name (First, Middle, Maiden Surname) Marion Morris		
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) Lisa E. Sopourn/Daughter		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 153 Mesa Circle, Lafayette, Colorado 80026		
	20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Metropolitan Crematory		20c. Location - City or Town, State Alex., Virginia
To Be Completed by Physician/Medical Examiner	21. Signature of Funeral Service Licensee John F. DeVol		22. Name and Address of Facility DeVol Funeral Home 2222 Wisconsin Ave., N.W. Washington, D.C. 20007		
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		Approximate Interval Between Onset and Death MINUTES YEARS		
To Be Completed by Physician/Medical Examiner	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 4 <input type="checkbox"/> Pregnant at time of death 9 <input type="checkbox"/> Unknown		23d. Date of delivery Month Day Year
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Hypertension Hypertlipidemia		23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown		
To Be Completed by Physician/Medical Examiner	24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		
	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> Outpatient 3 <input type="checkbox"/> OOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		
To Be Completed by Physician/Medical Examiner	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M
	28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred		
To Be Completed by Physician/Medical Examiner	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)		
	29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier M.D.		
To Be Completed by Physician/Medical Examiner	29c. License number D37024		29d. Date signed (Month, Day, Year) JANUARY 17, 2004		
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DAVID SPOUR 9901 MEDICAL CENTER DRIVE ROCKVILLE MD. 20850				
State Registrar	31. Date filed (Month, Day, Year) JAN 21 2004		32. Registrar's Signature Sparks		

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2004 03944

1- For
State
Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Selma Bookbinder Solon				2. Date of Death Month Day Year January 14, 2004		3. Time of Death 7:35 P.M.	
	4a. Facility Name (If not institution, give street and number) Montgomery General Hospital				4b. City, Town, or Location of Death Olney		4c. County of Death Montgomery	
Funeral Director	5. Social Security Number 209-36-2108	6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 84 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) July 19, 1919		9. Birthplace (State or Foreign Country) New York
	Usual Residence of Decedent							
To Be Completed by Funeral Director	10a. State Maryland	10b. County Montgomery	10c. City, Town or Location Wheaton		10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No			
	10e. Street and Number 13104 Matey Road			10f. Zip Code 20906		10g. Citizen of What Country? United States		
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 0		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker		16b. Kind of Business/Industry Own Home			
	17. Father's Name (First, Middle, Last) Nathan Bookbinder				18. Mother's Name (First, Middle, Maiden Surname) Ida Ellen Bookbinder			
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) Jerry Alan Solon/ Husband				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1310 Matey Road, Wheaton, MD 20906			
	20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input checked="" type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Geo. Wash. University Medical Center		Date January 15, 2004		20c. Location - City or Town, State Washington, D.C.	
	21. Signature of Funeral Service Licensee <i>[Signature]</i>				22. Name and Address of Facility Columbia Mortuary Services, Inc P.O. Box 58007 Washington, D.C. 20037			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Myocardial Infarction							
	23b. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Cerebro-Vascular Accident Diabetes Mellitus							
To Be Completed by Physician/Medical Examiner	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 9 <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) 9 <input type="checkbox"/> Unknown		23d. Date of delivery Month Day Year			
	24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No			
	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28d. Describe how injury occurred			
State Registrar	29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				29b. Signature and title of certifier <i>Wilkinson J. Ninala</i>			
	29c. License number D45285				29d. Date signed (Month, Day, Year) January 14, 2004			
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) WJ Ninala, 344 University Blvd #113, Silver Spring, Md 20901							
31. Date filed (Month, Day, Year) JAN 21 2004				32. Registrar's Signature <i>[Signature]</i>				

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2004 03945

1- For
State
RegistrarPhysician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Catherine Whitaker Siegel

2. Date of Death

January 12, 2004

3. Time of Death

11:00 a M

Funeral
Director

4a. Facility Name (If not institution, give street and number)

4601 North Park Avenue #505

4b. City, Town, or Location of Death

Chevy Chase

4c. County of Death

Montgomery

5. Social Security Number

354.12.0765

6. Sex

1 ☐ M ☒ F

7. Age (In yrs. last birthday)

79 Yrs.

If Under 1 Year

Months

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

April 14, 1924

9. Birthplace (State or Foreign Country)

Illinois

Usual Residence of Decedent

10a. State

MD

10b. County

Montgomery

10c. City, Town or Location

Chevy Chase

10d. Inside City Limits

1 ☐ Yes ☒ No

10e. Street and Number

4601 North Park Avenue #505

10f. Zip Code

20815

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: White

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4or 5+)

4

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Secretary

16b. Kind of Business/Industry

Administration

17. Father's Name (First, Middle, Last)

Garfield Whitaker

18. Mother's Name (First, Middle, Maiden Surname)

Catherine Leaver

19a. Informant's Name/Relationship (Type, Print)

Scott Siegil/ Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

21 Meridith Court Monmouth Beach, N.J. 07750

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Mt. Comfort Crematory 1/16/2004

Date

20c. Location - City or Town, State

Alexandria, VA

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Joseph Gawler's Sons, Inc.

5130 Wisconsin Avenue NW WDC 20016

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

a. Cardiac Dysrhythmia

Due to (or as a consequence of):

b. Coronary Artery Disease

Due to (or as a consequence of):

c. Hypertension

Due to (or as a consequence of):

d.

Approximate
Interval Between
Onset and Death

5 years

15 years

IF FEMALE:

23b. Was decedent pregnant
in the past 12 months?1 ☐ Yes 2 ☒ No
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy
4 ☐ Pregnant at time of death 5 ☐ Other (specify)
9 ☐ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Breast Cancer

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an
autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings available
prior to completion of cause of
death?1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home5 ☒ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending
2 ☐ Accident investigation
3 ☐ Suicide 6 ☐ Could not be
4 ☐ Homicide determined

28a. Date of Injury

(Month, Day Year)

28b. Time of
Injury28c. Injury at
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
and manner stated.

29b. Signature and title of certifier

Bryan Arling MD.

29c. License number

DC 5824

29d. Date signed (Month, Day, Year)

January 15, 2004

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Bryan Arling, MD., 2440 M St., #817, Washington D.C. 20037

State
Registrar

31. Date filed (Month, Day, Year)

JAN 20 2004

32. Registrar's Signature

Bryan Arling

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show
any injury or other traumatic event, the Medical Examiner must be notified at
once.To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification; To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2004 03946

1- For
State
Registrar

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Carlton R. Sickles				2. Date of Death Month Day Year January 17, 2004		3. Time of Death 7:26A M	
	4a. Facility Name (If not institution, give street and number) 6603 Old Stage Road				4b. City, Town, or Location of Death North Bethesda		4c. County of Death Montgomery	
Funeral Director	5. Social Security Number 579-18-2056		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 82 Yrs.		8. Date of Birth (Month, Day, Year) June 15, 1921	
	9. Birthplace (State or Foreign Country) Connecticut		10a. State Maryland		10b. County Montgomery		10c. City, Town or Location North Bethesda	
To Be Completed by Funeral Director	10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		10e. Street and Number 6603 Old Stage Road		10f. Zip Code 20852		10g. Citizen of What Country? United States	
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: World War II Korea		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White	
To Be Completed by Physician/Medical Examiner	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 5+ College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Lawyer		16b. Kind of Business/Industry Pension and Health Administration			
	17. Father's Name (First, Middle, Last) Carl W. Sickles				18. Mother's Name (First, Middle, Maiden Surname) Louise E. Torello			
Physician /Medical Examiner	19a. Informant's Name/Relationship (Type, Print) Jacqueline Eig Sickles/Wife				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6603 Old Stage Road, North Bethesda, Maryland 20852			
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) George Washington Cemetery		20c. Location - City or Town, State Adelphi, Maryland		20d. Date January 21, 2004	
To Be Completed by Physician/Medical Examiner	21. Signature of Funeral Service Licensee David E. Perry M00803		22. Name and Address of Facility Robert A. Pumphrey Funeral Home/ Bethesda-Chevy Chase, Inc. 7557 Wisconsin Avenue Bethesda, Maryland 20814-3501		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Congestive Heart Failure		Approximate Interval Between Onset and Death Weeks	
	23b. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Hyperlipidemia, s/p Mitral Valve Replacement s/p Pacemaker Placement		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify)		23d. Date of delivery Month Day Year		23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown	
To Be Completed by Physician/Medical Examiner	24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No		25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)	
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
To Be Completed by Physician/Medical Examiner	28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)		29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.	
	29b. Signature and title of certifier E. P. Libre MD		29c. License number D09470		29d. Date signed (Month, Day, Year) January 19, 2004		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Eugene P. Libre, M.D. 10400 Connecticut Avenue, #606, Kensington, MD 20895	
State Registrar	31. Date filed (Month, Day, Year) JAN 20 2004		32. Registrar's Signature [Signature]					

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2004 03947

1- For State Registrar

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Physician /Medical Examiner

Funeral Director

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

1. Decedent's Name (First, Middle, Last) Lottie Shock		2. Date of Death Month Day Year 1-20-2004		3. Time of Death 8:03 A. M	
4a. Facility Name (If not institution, give street and number) Green Acre Assisted Living		4b. City, Town, or Location of Death Silver Spring		4c. County of Death Montgomery	
5. Social Security Number 463-12-9976	6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 95 Yrs.	8. Date of Birth (Month, Day, Year) 3-5-1908	9. Birthplace (State or Foreign Country) Texas	
Usual Residence of Decedent		10a. State MD		10b. County Montgomery	
10c. City, Town or Location Silver Spring		10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No			
10e. Street and Number 200 Greenspring Lane		10f. Zip Code 20904		10g. Citizen of What Country? USA	
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:	
14. Race - American Indian, Black, White, etc. Specify: White		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 1 College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Secretary	
16b. Kind of Business/Industry OK Conf. of SDA		17. Father's Name (First, Middle, Last) Rufus LaMascus		18. Mother's Name (First, Middle, Maiden Surname) Maude Dane	
19a. Informant's Name/Relationship (Type, Print) Pat Knauss - Daughter		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 200 Greenspring Ln. Silver Spring, MD 20904			
20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Ft. Lincoln Crem.		20c. Location - City or Town, State Brentwood, MD	
21. Signature of Funeral Service Licensee 		22. Name and Address of Facility Hines-Rinaldi F. H. 11800 New Hampshire Ave. Silver Spring, MD 20904			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Essential Hypertension Due to (or as a consequence of): b. Atrial Fibrillation Due to (or as a consequence of): c. Due to (or as a consequence of): d. Approximate Interval Between Onset and Death 3 years 3 years					
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 9 <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 4 <input type="checkbox"/> Pregnant at time of death 9 <input type="checkbox"/> Unknown		23d. Date of delivery Month Day Year	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Degenerative Brain Disorder					
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other (Specify) Assisted Living			
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M	
28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred			
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.					
29b. Signature and title of certifier 		29c. License number D03835		29d. Date signed (Month, Day, Year) January 21, 2004	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) David Cromwell, M. D. 831 University Blvd. E. Suite #37 Silver Spring, MD 20903					
31. Date filed (Month, Day, Year) JAN 23 2004		32. Registrar's Signature 			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

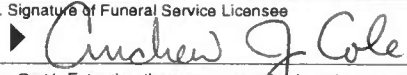


State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2004 03948

1- For State Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Milton Alexander Schellenberg				2. Date of Death Month Day Year January 18, 2004		3. Time of Death 2:50 a M	
	4a. Facility Name (If not institution, give street and number) Suburban Hospital				4b. City, Town, or Location of Death Bethesda		4c. County of Death Montgomery	
Funeral Director	5. Social Security Number 579-60-8137	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 95 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) Jan. 2, 1909	9. Birthplace (State or Foreign Country) Washington, DC	
	Usual Residence of Decedent							
To Be Completed by Funeral Director	10a. State Maryland	10b. County Montgomery	10c. City, Town or Location Bethesda			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
	10e. Street and Number 6904 River Road			10f. Zip Code 20817		10g. Citizen of What Country? USA		
	11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 5+		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Catholic Priest		16b. Kind of Business/Industry Religious			
	17. Father's Name (First, Middle, Last) William Schellenberg			18. Mother's Name (First, Middle, Maiden Surname) Mary Mack				
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) Thomas L. Samsel/Nephew			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 15416 Quail Run Drive, Darnestown, MD 20878				
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Gate of Heaven Cemetery		Date January 23 2004		20c. Location - City or Town, State Silver Spring, MD	
	21. Signature of Funeral Service Licensee 		22. Name and Address of Facility Francis J. Collins Funeral Home Inc. 500 University Blvd. W., Silver Spring, MD 20901					
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Respiratory Failure Due to (or as a consequence of): b. Aspiration Pneumonia Due to (or as a consequence of): c. Stroke Due to (or as a consequence of): d. Atrial Fibrillation Approximate Interval Between Onset and Death							
	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown 23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <input type="checkbox"/> Unknown 23d. Date of delivery Month Day Year							
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								
To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28d. Describe how injury occurred					
	28f. Location (Street and Number or Rural Route Number, City or Town, State)							
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.							
State Registrar	29b. Signature and title of certifier 		29c. License number MD 40576		29d. Date signed (Month, Day, Year) January 18, 2004			
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Ramin Oskoui M.D. 3301 New Mexico Ave., NW, Washington, DC 20016							
31. Date filed (Month, Day, Year) JAN 23 2004		32. Registrar's Signature 						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2004 03949

1- For
State
RegistrarPhysician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

SHERMAN ALLEN SAUNDERS

2. Date of Death

JAN. 20, 2004

3. Time of Death

8:44 AM

4a. Facility Name (If not institution, give street and number)

2129 Hallmark Drive

4b. City, Town, or Location of Death

Gambrills

4c. County of Death

ANNE ARUNDEL

Funeral
Director

5. Social Security Number

210-40-2554

6. Sex

M ☒ F ☐

7. Age (In yrs. last birthday)

50 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth (Month, Day, Year)

Mar. 4, 1953

9. Birthplace (State or Foreign Country)

Pennsylvania

Usual Residence of Decedent

10a. State

MD

10b. County

Anne Arundel

10c. City, Town or Location

Gambrills

10d. Inside City Limits

☒ Yes ☐ No

10e. Street and Number

2129 Hallmark Drive

10f. Zip Code

21054

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

5+

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Minister

16b. Kind of Business/Industry

Religion

17. Father's Name (First, Middle, Last)

Unknown

18. Mother's Name (First, Middle, Maiden Surname)

Eva Saunders

19a. Informant's Name/Relationship (Type, Print)

Daun Lewis (Sister)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2129 Hallmark Dr., Gambrills, MD 21054

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Metro Funeral Srv

Date

1/26/04

20c. Location - City or Town, State

Alexandria, VA

21. Signature of Funeral Service Licensee

George R. Snowden

22. Name and Address of Facility

SNOWDEN FUNERAL HOME, P.A.
246 N. Wash. St., Rockville, MD 20850

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. RESPIRATORY FAILURE
Due to (or as a consequence of):

Approximate Interval Between Onset and Death

2 mo

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. MOTOR NEURON DISEASE
Due to (or as a consequence of):

3 YEARS

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☐ No
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy
4 ☐ Pregnant at time of death 5 ☐ Other (specify)
9 ☐ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

NONE

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ D/OA

Other:

4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

29b. Signature and title of certifier

Ahmet Hoke

STAFF
NEUROLOGIST

29c. License number

D 46686

29d. Date signed (Month, Day, Year)

1/21/2004

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Ahmet Hoke, M.D. 600 N. Wolfe Street, Baltimore, MD 21205

31. Date filed (Month, Day, Year)

JAN 22 2004

32. Registrar's Signature

Sparks

State
Registrar

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Kenneth Sydnor
04-00241
CM

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene
Certificate of Death

2004 03950

1. For State Registrar

Amend Item #1

per me 6828 2/20/04 tas

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Kenneth Sydnor Kenneth James Sydnor		2. Date of Death Month Day Year January 10, 2004		3. Time of Death 12:24 A ^M	
	4a. Facility Name (If not institution, give street and number) Southern Maryland Hospital Center		4b. City, Town, or Location of Death Clinton		4c. County of Death Prince George's	
Funeral Director	5. Social Security Number 578-88-2275	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 42 Yrs.	8. Date of Birth (Month, Day, Year) Dec. 3, 1961		9. Birthplace (State or Foreign Country) Virginia
	10a. State District of Columbia		10b. County Washington		10c. City, Town or Location Washington	
To Be Completed by Funeral Director	10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		10e. Street and Number 3600 Ely Place, S.E. #118		10f. Zip Code 20019	
	10g. Citizen of What Country? United States		11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:	
To Be Completed by Physician/Medical Examiner	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: Black		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 10th College (1-4or 5+)	
	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Public Works		16b. Kind of Business/Industry Private		17. Father's Name (First, Middle, Last) Ronald S. Gray	
To Be Completed by Physician/Medical Examiner	18. Mother's Name (First, Middle, Maiden Surname) Marjorie Mont		19a. Informant's Name/Relationship (Type, Print) Marjorie Sydnor - Mother		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3600 Ely Pl., S.E. #118, Wash., DC 20019	
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Evergreen Cemetery		20c. Location - City or Town, State 1/18/2004 Milford, VA	
To Be Completed by Physician/Medical Examiner	21. Signature of Funeral Service Licensee John T. Stewart III		22. Name and Address of Facility Stewart Funeral Home 4001 Benning Rd., N.E. Wash., DC 20019		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. HYPERTENSIVE CARDIOVASCULAR DISEASE Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	
	23b. IF FEMALE: Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <input type="checkbox"/> Unknown		23d. Date of delivery Month Day Year	
To Be Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown		24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
	24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)	
To Be Completed by Physician/Medical Examiner	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M	
	28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	
To Be Completed by Physician/Medical Examiner	28f. Location (Street and Number or Rural Route Number, City or Town, State)		29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier Mary Ann A. Korosec MD	
	29c. License number O.C.M.E.		29d. Date signed (Month, Day, Year) January 10, 2004		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Mary Ann A. Korosec 111 Penn Street, Baltimore, Maryland 21201	
To Be Completed by Physician/Medical Examiner	31. Date filed (Month, Day, Year) JAN 22 2004		32. Registrar's Signature Kenneth Sydnor		33. State Registrar JAN 22 2004	

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2004 03951

1- For
State
RegistrarPhysician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

SYLVIA PLATER SMITH

2. Date of Death

Month Day Year
JANUARY 13 2004

3. Time of Death

12:26 PM

Funeral
Director

4a. Facility Name (If not institution, give street and number)

DOCTOR'S COMMUNITY HOSPITAL

4b. City, Town, or Location of Death

LANHAM

4c. County of Death

PRINCE GEORGE'S

5. Social Security Number

577-46-1488

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

70

If Under 1 Year

Months

If Under 24 Hrs.

Hours

8. Date of Birth

(Month, Day, Year)

8 19 1933

9. Birthplace (State or Foreign Country)

MARYLAND

Usual Residence of Decedent

10a. State

MD

10b. County

PRINCE GEORGE'S

10c. City, Town or Location

LANHAM

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

9803 STALL AVENUE

10f. Zip Code

20706

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: BLACK

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

2

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

POSTAL CLERK

16b. Kind of Business/Industry

GOVERNMENT

17. Father's Name (First, Middle, Last)

EARL LEON PLATER SR.

18. Mother's Name (First, Middle, Maiden Surname)

EDNA Tabbs

19a. Informant's Name/Relationship (Type, Print)

JAMES EARL SMITH

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

9803 STALL AVENUE LANHAM, MARYLAND 20706

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Maryland National

Date

1-20-2004

20c. Location - City or Town, State

LAUREL, MARYLAND

21. Signature of Funeral Service Licensee

22. Name and Address of Facility J. B. JENKINS FUNERAL HOME

7474 LANDOVER ROAD LANDOVER, MARYLAND 20785

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Approximate
Interval Between
Onset and DeathImmediate Cause (Final
disease or condition
resulting in death)

a. CARDIOGENIC SHOCK

Due to (or as a consequence of):

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

b. ACUTE MYOCARDIAL INFARCTION

Due to (or as a consequence of):

c. DIABETES

Due to (or as a consequence of):

IF FEMALE:

23b. Was decedent pregnant
in the past 12 months?1 ☐ Yes 2 ☒ No
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown3 ☐ Ectopic pregnancy
5 ☐ Other (specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

RESPIRATORY FAILURE

RENAL FAILURE

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an
autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings available
prior to completion of cause of
death?1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending
investigation
2 ☐ Accident 6 ☐ Could not be
determined
3 ☐ Suicide 4 ☐ Homicide28a. Date of Injury
(Month, Day Year)28b. Time of
Injury

M

28c. Injury at
Work?1 ☐ Yes 2 ☐ No28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)29. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
and manner stated.

29b. Signature and title of certifier

29c. License number

D34525

29d. Date signed (Month, Day, Year)

1-16-04

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

JANARDHAN S. RAO M.D. 4000 MITCHELLVILLE ROAD SUITE 220 BOWIE MD 20718

31. Date filed (Month, Day, Year)

JAN 21 2004

32. Registrar's Signature

Mark S. Spink

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show
any injury or other traumatic event, the Medical Examiner must be notified at
once.Physician
/Medical
ExaminerTo the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit
certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

1- For
State
Registrar

2004 03952

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Debra Ann Saulino			2. Date of Death Month Day Year Jan. 11 2004		3. Time of Death 2:02 P M		
	4a. Facility Name (If not institution, give street and number) Laurel Regional Hospital			4b. City, Town, or Location of Death Laurel		4c. County of Death Prince George's		
Funeral Director	5. Social Security Number 577-74-8421		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 50 Yrs.		8. Date of Birth (Month, Day, Year) Apr. 28, 1953	
	9. Birthplace (State or Foreign Country) Wash., D.C.		10a. State MD		10b. County Prince George's		10c. City, Town or Location Bowie	
To Be Completed by Funeral Director	10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		10e. Street and Number 12711 Buckingham Drive		10f. Zip Code 20715		10g. Citizen of What Country? USA	
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White	
To Be Completed by Physician/Medical Examiner	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4or 5+) 12		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Administrative Assistant		16b. Kind of Business/Industry Marketing			
	17. Father's Name (First, Middle, Last) George E. Frazee, Sr.		18. Mother's Name (First, Middle, Maiden Surname) Patricia Ann Elliott		19a. Informant's Name/Relationship (Type, Print) Edward L. Frazee / brother		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12711 Buckingham Dr. Bowie, MD. 20715	
Physician /Medical Examiner	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Lakemont Mem. Gardens		Date 1-24-2004		20c. Location - City or Town, State Davidsonville, MD.	
	21. Signature of Funeral Service Licensee E. Brian Powell		22. Name and Address of Facility Beall Funeral Home 6512 NW Crain Highway Bowie, MD. 20715		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Defect in aortic aneurysm repair with hemorrhage Due to (or as a consequence of): b. and massive left pleural effusion Due to (or as a consequence of): c. Due to (or as a consequence of): d.		Approximate Interval Between Onset and Death	
To Be Completed by Physician/Medical Examiner	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 9 <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 4 <input type="checkbox"/> Pregnant at time of death 9 <input type="checkbox"/> Unknown 3 <input type="checkbox"/> Ectopic pregnancy 5 <input type="checkbox"/> Other (specify)		23d. Date of delivery Month Day Year			
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Aortic aneurysm repair Infarction of bowel		25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined	
To Be Completed by Physician/Medical Examiner	28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred	
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)		29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier Syed Sadiq, M.D.	
State Registrar	29c. License number D 24721		29d. Date signed (Month, Day, Year) January 13, 2004		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Syed Sadiq, M.D. 14333 Laurel Bowie Rd. Laurel, MD. 20708		31. Date filed (Month, Day, Year) JAN 20 2004	
	32. Registrar's Signature [Signature]							

Baltimore, Maryland 21215-0036
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.Division of Vital Records, P.O. Box 68760,
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2004 03954

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician / Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

1. Decedent's Name (First, Middle, Last) THELMA STACKHOUSE		2. Date of Death Month January Day 9 Year 2004		3. Time of Death 5:10 AM			
4a. Facility Name (If not institution, give street and number) Prince George's Hospital & Nursing Home			4b. City, Town, or Location of Death Cheverly		4c. County of Death Prince George's		
5. Social Security Number 579-20-1688		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 78 Yrs.		8. Date of Birth (Month, Day, Year) May 13, 1925	
9. Birthplace (State or Foreign Country) unknown		10a. State MD		10b. County Prince George's		10c. City, Town or Location Cheverly	
10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		10e. Street and Number 2900 Mercy Lane		10f. Zip Code 20785		10g. Citizen of What Country? USA	
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced unknown		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: unknown		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: Black	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) unknown		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) unknown		16b. Kind of Business/Industry unknown		17. Father's Name (First, Middle, Last) unknown	
18. Mother's Name (First, Middle, Maiden Summa) unknown		19a. Informant's Name/Relationship (Type, Print) Joann Butler/Guardian Specialist		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5012 Rhode Island Avenue, Hyattsville, MD 20781		20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)	
20b. Place of Disposition (Name of cemetery, crematory or other place) Metropolitan Crematory		Date 1/14/04		20c. Location - City or Town, State Alexandria, VA		21. Signature of Funeral Service Licensee John F. Bobel	
22. Name and Address of Facility Cedar Hill Funeral Home, Inc. 4111 Pennsylvania Ave., Suitland, MD 20746		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Septic		Approximate Interval Between Onset and Death 5 days		23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown	
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)	
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)		29a. Certifier <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.	
29b. Signature and title of certifier John F. Bobel		29c. License number 225079		29d. Date signed (Month, Day, Year) 1/14/04		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Don W. Tablanovich, no 2409 Executive Pl. #202, Lorton, VA 22070	
31. Date filed (Month, Day, Year) JAN 22 2004		32. Registrar's Signature John F. Bobel		33. State Registrar CR (2)		34. State Registrar CR (2)	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

1- For State Registrar

2004 03955

Baltimore, Maryland 21215-0036
 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
 Important: If item 27 is marked other than "Natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,
 To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
 To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) MARIE ADELE TYDINGS			2. Date of Death Month Day Year JANUARY 20 2004		3. Time of Death 18:39 PM
	4a. Facility Name (If not institution, give street and number) MONTGOMERY GENERAL HOSPITAL		4b. City, Town, or Location of Death OLNEY		4c. County of Death MONTGOMERY	
Funeral Director	5. Social Security Number 056 16 3356	6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 84 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) Jan. 28 1919
	9. Birthplace (State or Foreign Country) New York					
To Be Completed by Funeral Director	Usual Residence of Decedent		10a. State Md.		10b. County Montgomery	
	10c. City, Town or Location Silver Spring		10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			
	10e. Street and Number 15423 Bassett Lane		10f. Zip Code 20906		10g. Citizen of What Country? United States	
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:	
	14. Race - American Indian, Black, White, etc. Specify: White					
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 4		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker		16b. Kind of Business/Industry Own Home	
	17. Father's Name (First, Middle, Last) Leon Joseph Roversi		18. Mother's Name (First, Middle, Maiden Surname) Mary Murphy			
	19a. Informant's Name/Relationship (Type, Print) Richard T. Lichtermann / Husband		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 15423 Bassett Lane, Silver Spring, Md. 20906			
	20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Metropolitan Crem.		20c. Location - City or Town, State Alexandria, Va.	
	20d. Date 1/21/04					
21. Signature of Funeral Service Licensee Muriel H. Barber		22. Name and Address of Facility Muriel H. Barber Funeral Home P. O. Box 5038, Laytonsville, Md. 20882				
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) INTRACRANIAL BLEED a. Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of):					Approximate Interval Between Onset and Death 3 Days
	23b. IF FEMALE: Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 9 <input type="checkbox"/> Unknown					23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) 9 <input type="checkbox"/> Unknown
	23d. Date of delivery Month Day Year					
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. HYPERTENSION CHRONIC RENAL FAILURE ARTHRITIS					23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown
	24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No					24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M	
	28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred			
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
	29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.					
29b. Signature and title of certifier Arthur Schoengold, M.D.		29c. License number D18726		29d. Date signed (Month, Day, Year) JANUARY 21, 2004		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ARTHUR SCHOENGOLD, M.D. 18111 PRINCE PHILIP DRIVE, OLNEY, MD. 20832						
31. Date filed (Month, Day, Year) JAN 22 2004		32. Registrar's Signature [Signature]				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2004 03956

1- For
State
RegistrarPhysician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Chan Van Truong

2. Date of Death

Month Day Year
January 10 2004

3. Time of Death

10:00 PM

Funeral
Director

4a. Facility Name (If not institution, give street and number)

Doctor's Community Hospital

4b. City, Town, or Location of Death

Lanham

4c. County of Death

Prince George's

5. Social Security Number

214-96-1374

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

50 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
July 3, 1953

9. Birthplace (State or Foreign Country)

Viet Nam

Usual Residence of Decedent

10a. State

Maryland

10b. County

Prince George's

10c. City, Town or Location

Lanham

10d. Inside City Limits

☐ Yes ☒ No

10e. Street and Number

7631 Seans Terrace

10f. Zip Code

20706

10g. Citizen of What Country?

U.S.A.

11. Marital Status

☐ Never Married ☒ Married
☐ Widowed ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
☐ Yes ☒ No
If Yes, Give
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)☐ Yes ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: Asian

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

9

College (1-4or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Machine Operator

16b. Kind of Business/Industry

Airplane Parts

17. Father's Name (First, Middle, Last)

Ky Van Truong

18. Mother's Name (First, Middle, Maiden Surname)

Nguu Thi Huynh

19a. Informant's Name/Relationship (Type, Print)

Trai Nguyen / wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

7631 Seans Terrace, Lanham, Maryland 20706

20a. Method of Disposition

☐ Burial ☒ Cremation ☐ Removal from State
☐ Donation ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Fort Lincoln Crematory 1-15-2004

Date

20c. Location - City or Town, State

Brentwood, Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility Hines-Rinaldi Funeral Home, Inc.
11800 New Hampshire Av., Silver Spring, MD 2090423a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Approximate
Interval Between
Onset and DeathImmediate Cause (Final
disease or condition
resulting in death)

Lung Cancer

a. Due to (or as a consequence of):

Brain Metastasis

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

IF FEMALE:

23b. Was decedent pregnant
in the past 12 months?
☐ Yes ☒ No
☐ Unknown

23c. If yes, outcome of pregnancy

☐ Live birth ☐ Fetal death ☐ Ectopic pregnancy
☐ Pregnant at time of death ☐ Other (specify)
☐ Unknown23d. Date of delivery
Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

☐ Yes ☒ No ☐ Probably ☐ Unknown24a. Was an
autopsy
performed?
☐ Yes ☒ No24b. Were autopsy findings available
prior to completion of cause of
death?
☐ Yes ☒ No25. Was case referred to medical
examiner?
☐ Yes ☒ No26. Place of Death (Check only one)
Hospital: ☒ Inpatient ☐ ER/Outpatient ☐ DOA Other: ☐ Nursing Home ☐ Residence ☐ Other (Specify)

27. Manner of Death

☒ Natural ☐ Pending investigation
☐ Accident ☐ Could not be determined
☐ Suicide ☐ Homicide28a. Date of Injury
(Month, Day Year)28b. Time of
Injury28c. Injury at
Work?
☐ Yes ☒ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D58182

29d. Date signed (Month, Day, Year)

January 12, 2004

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Cecil D. George, M.D.

7305 - A Hanover Parkway, Greenbelt, Maryland 20770

State
Registrar

31. Date filed (Month, Day, Year)

JAN 22 2004

32. Registrar's Signature

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show
any injury or other traumatic event, the Medical Examiner must be notified at
once.Physician
/Medical
ExaminerTo the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2004 03957

1- For
State
RegistrarPhysician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Marina Tovar

2. Date of Death

1-15-04

Day Year

3. Time of Death

10:45 A M

4a. Facility Name (If not institution, give street and number)

Holy Cross Hospital

4b. City, Town, or Location of Death

Silver Spring

4c. County of Death

Montgomery

Funeral
Director

5. Social Security Number

577-72-1547

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

55 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

8-8-48

9. Birthplace (State or Foreign Country)

Columbia

Usual Residence of Decedent

10a. State

MD

10b. County

Montgomery

10c. City, Town or Location

Silver Spring

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

2102 Harlequin Terr

10f. Zip Code

20904

10g. Citizen of What Country?

Columbia

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☒ Yes 2 ☐ No Specify: Columbian

14. Race - American Indian, Black, White, etc.

Specify: Hispanic

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

12

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Nursing Assistant

16b. Kind of Business/Industry

Nursing Home

17. Father's Name (First, Middle, Last)

Marco Antonio Tovar

18. Mother's Name (First, Middle, Maiden Surname)

Maria O. Bonilla

19a. Informant's Name/Relationship (Type, Print)

Victoria Marin -daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2102 Harlequin Terr. Silver Spring, MD 20904

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Gate of Heaven

Date

1-20-04

20c. Location - City or Town, State

Silver Spring, MD

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Hines-Rinaldi F. H.

11800 New Hampshire Ave. Silver Spring, MD 20904

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Metastatic uterine cancer

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☒ No
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 5 ☐ Other (specify)
9 ☐ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an autopsy performed?
1 ☐ Yes 2 ☒ No24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No25. Was case referred to medical examiner?
1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation
2 ☐ Accident 6 ☐ Could not be determined
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number

D52261

29d. Date signed (Month, Day, Year)

1-15-04

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Alan R. Segal M. S. 1517 Hugo Cir. Silver Spring, MD 20906

31. Date filed (Month, Day, Year)

JAN 20 2004

32. Registrar's Signature

State
Registrar

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23e or 28e-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2004 03958

1- For
State
Registrar

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Shirley Jean Thompson

2. Date of Death

January 12, 2004

3. Time of Death

3:36P. M

Funeral
Director

4a. Facility Name (If not institution, give street and number)

Laurel Regional Hospital

4b. City, Town, or Location of Death

Laurel

4c. County of Death

Prince George's

5. Social Security Number

213-44-6873

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

75 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
Nov. 1, 1928

9. Birthplace (State or Foreign Country)

Pennsylvania

Usual Residence of Decedent

10a. State
Maryland10b. County
Prince George's10c. City, Town or Location
Beltsville

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

4508 Tonquil Place

10f. Zip Code

20705

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: White

15. Decedent's Education
(Specify only highest grade completed)Elementary/Secondary (0-12)
12

College (1-4 or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Administrative Assistant

16b. Kind of Business/Industry

Federal Government

17. Father's Name (First, Middle, Last)

James Cousins Hepler

18. Mother's Name (First, Middle, Maiden Surname)

Edna Hepler

19a. Informant's Name/Relationship (Type, Print)

Edwin R. Thompson, Jr. -Husband

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

4508 Tonquil Place Beltsville, Maryland 20705

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Metropolitan Crematory 1/17/2004

Date

20c. Location - City or Town, State

Alexandria, Virginia

21. Signature of Funeral Service Licensee

Donald V. Borgwardt

22. Name and Address of Facility

Donald V. Borgwardt Funeral Home, P.A.

4400 Powder Mill Rd. Beltsville, Maryland 20705

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)a. Due to (or as a consequence of):
Heart failureb. Due to (or as a consequence of):
Hypertension

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate
Interval Between
Onset and Death

IF FEMALE:

23b. Was decedent pregnant
in the past 12 months?1 ☐ Yes 2 ☒ No
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy
4 ☐ Pregnant at time of death 5 ☐ Other (specify)
9 ☐ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23a. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an
autopsy
performed?
1 ☐ Yes 2 ☒ No24b. Were autopsy findings available
prior to completion of cause of
death?
1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?
1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☒ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending
2 ☐ Accident investigation
3 ☐ Suicide 6 ☐ Could not be
4 ☐ Homicide determined

28a. Date of Injury

(Month, Day Year)

28b. Time of
Injury28c. Injury at
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
and manner stated.

29b. Signature and title of certifier

Raim MD

29c. License number

D0053709

29d. Date signed (Month, Day, Year)

1/14/04

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

KAS CHAWLA 3060 mitchellville rd Bowie MD 20716

State
Registrar

31. Date filed (Month, Day, Year)

JAN 21 2004

32. Registrar's Signature

Benjamin S. Sparks

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2004 03959

Baltimore, Maryland 21215-0020
 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
 Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

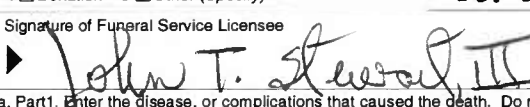
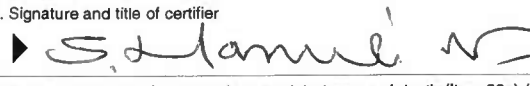

Division of Vital Records, P.O. Box 68760,
 To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
 To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Physician
/Medical
Examiner

Funeral
Director

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

1. Decedent's Name (First, Middle, Last) James C. Turner, Sr.				2. Date of Death Month January Day 15 Year 2004		3. Time of Death 11:30 AM	
4a. Facility Name (If not institution, give street and number) St. Thomas More Nursing Home				4b. City, Town, or Location of Death Hyattsville		4c. County of Death Prince George's	
5. Social Security Number 579-50-6969		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 63 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) June 1, 1940	
9. Birthplace (State or Foreign Country) Wash., DC							
10a. State Maryland		10b. County Prince George's		10c. City, Town or Location Hyattsville		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
10e. Street and Number 4922 LaSalle Road				10f. Zip Code 20782		10g. Citizen of What Country? United States	
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: Black	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12th College (1-4or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Truck Driver		16b. Kind of Business/Industry Private	
17. Father's Name (First, Middle, Last) James Howard				18. Mother's Name (First, Middle, Maiden Surname) Ethel Hairston			
19a. Informant's Name/Relationship (Type, Print) James C. Turner, Jr. - Son				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5104 Kenilworth Ave., #6, Hyattsville, MD 20781			
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Ft. Lincoln Cemetery		Date 1/22/04		20c. Location - City or Town, State Brentwood, MD	
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility Stewart Funeral Home 4001 Benning Rd., N.E. Wash., DC 20019			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Duodenal Cancer Due to (or as a consequence of): b. _____ Due to (or as a consequence of): c. _____ Due to (or as a consequence of): d. _____ Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last						Approximate Interval Between Onset and Death	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Coronary Artery Disease Hypertension						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown	
						24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
						24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No	
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No	
28d. Describe how injury occurred				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			
28f. Location (Street and Number or Rural Route Number, City or Town, State)							
29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier 		29c. License number D0058390		29d. Date signed (Month, Day, Year) January 16, 2004	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) S. Hamwi, M.D. 1328 Southern Ave., #307, Wash., DC 20032							
31. Date filed (Month, Day, Year) JAN 22 2004				32. Registrar's Signature 			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2004 03960

1- For
State
RegistrarPhysician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Janie C. Toy

2. Date of Death

January 10, 2004

3. Time of Death

4:59pm M

Funeral
Director

4a. Facility Name (If not institution, give street and number)

Southern Maryland Hospital

4b. City, Town, or Location of Death

Clinton

4c. County of Death

Prince Georges

5. Social Security Number

579-30-8578

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

76

Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

May 16, 1927

9. Birthplace (State or Foreign Country)

Ironsides, MD

Usual Residence of Decedent

10a. State

DC

10b. County

10c. City, Town or Location

Washington

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

703 10th St NE

10f. Zip Code

20002

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Private

17. Father's Name (First, Middle, Last)

John McKinley Posey

18. Mother's Name (First, Middle, Maiden Surname)

Marie Montgomery

19a. Informant's Name/Relationship (Type, Print)

William Toy Jr./ Husband

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

703 10th St NE Washington DC 20002

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Ft. Lincoln Cemetery 1/15/2004

Date

20c. Location - City or Town, State

Bladensburg, MD

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Alexander S. Pope Funeral Home
2617 Penn Ave SE Washington DC 20020

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Syphilis
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter underlying cause (Sequence of injury that initiated events resulting in death) Last

b.
Due to (or as a consequence of):c.
Due to (or as a consequence of):d.
Due to (or as a consequence of):

Approximate Interval Between Onset and Death

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☒ No
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy
4 ☐ Pregnant at time of death 5 ☐ Other (specify)
9 ☐ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Acute Renal Failure

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy performed?
1 ☐ Yes 2 ☒ No24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☒ No25. Was case referred to medical examiner?
1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation
2 ☐ Accident 6 ☐ Could not be determined
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number

D0055120

29d. Date signed (Month, Day, Year)

JAN 11 2004

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Richard Palmer MD 1328 Southern Ave SE Suite 310 Washington DC 20032

31. Date filed (Month, Day, Year)

JAN 21 2004

32. Registrar's Signature

State
Registrar

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at 4050.

Physician
/Medical
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State 1-20-04
Registrar Amend #29c. Per Phys. PGC cr

Certificate of Death

Reg. No.

2004 03961

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Physician
/Medical
ExaminerFuneral
Director

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

1. Decedent's Name (First, Middle, Last) Wendell Joseph Tracy		2. Date of Death Month Day Year January 14, 2004		3. Time of Death 11:51 P.M.	
4a. Facility Name (If not institution, give street and number) Prince George's Hospital Center		4b. City, Town, or Location of Death Cheverly		4c. County of Death Prince George's	
5. Social Security Number 578-12-1409	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 86 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) 9/10/17
9. Birthplace (State or Foreign Country) Wash., D.C.		10a. State D.C.			
10b. County Washington		10c. City, Town or Location Washington		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
10e. Street and Number 2015 Lawrence St., N.E.		10f. Zip Code 20018		10g. Citizen of What Country? U.S.A.	
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: 43-'45		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:	
14. Race - American Indian, Black, White, etc. Specify: Black		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <input type="checkbox"/> College (1-4 or 5+) <input checked="" type="checkbox"/> 2 yrs.		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Statistical Ass't.	
16b. Kind of Business/Industry Census Bureau U.S. Gov't.		17. Father's Name (First, Middle, Last) John E. Tracy		18. Mother's Name (First, Middle, Maiden Surname) Annie Martha Brown	
19a. Informant's Name/Relationship (Type, Print) Evelyn J. Tracy/Wife		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2015 Lawrence St., N.E., Wash., D.C. 20018			
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Arlington Nat'l. Cem.		20c. Location - City or Town, State 1/27/04 Ft. Myer, Va.	
21. Signature of Funeral Service Licensee 		22. Name and Address of Facility H.S. Washington & Sons Co., Inc. 4925 Burroughs Ave., N.E., Wash., D.C. 20019			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.					
Immediate Cause (Final disease or condition resulting in death)					
a. Cardiac Arrhythmia Due to (or as a consequence of):					
b. Due to (or as a consequence of):					
c. Due to (or as a consequence of):					
d. Due to (or as a consequence of):					
23b. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify)					
23c. Date of delivery Month Day Year					
23d. Date of delivery Month Day Year					
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.					
23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown					
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No					
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M	
28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred			
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) 1. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.					
29b. Signature and title of certifier 		29c. License number 12# D0023350		29d. Date signed (Month, Day, Year) 01-16-2004	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) John B. Theobalds, M.D. 3636 16th St., N.W. # A-G 69, Washington, D.C. 20010					
31. Date filed (Month, Day, Year) JAN 20 2004		32. Registrar's Signature 			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2004 03962

1- For
State
RegistrarPhysician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

DOREATHER G. TONEY

2. Date of Death

Month Day Year
JANUARY 16, 2004

3. Time of Death

12:00P M

4a. Facility Name (If not institution, give street and number)

PRINCE GEORGES HOSPITAL

4b. City, Town, or Location of Death

CHEVERLY

4c. County of Death

PRINCE GEORGES

Funeral
Director

5. Social Security Number

578 44 6649

6. Sex

1 ☐ M ☒ F

7. Age (In yrs. last birthday)

84 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
NOV. 06, 1919

9. Birthplace (State or Foreign Country)

SOUTH CAROLINA

Usual Residence of Decedent

10a. State

DC

10b. County

10c. City, Town or Location

WASHINGTON

10d. Inside City Limits

☒ Yes ☐ No

10e. Street and Number

4127 MINNESOTA AVE. NE

10f. Zip Code

20019

10g. Citizen of What Country?

UNITED STATES

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: BLACK

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

5TH

College (1-4or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working life. DO NOT use retired)

HOMEMAKER

16b. Kind of Business/Industry

17. Father's Name (First, Middle, Last)

JOHN HENRY GLADDEN

18. Mother's Name (First, Middle, Maiden Surname)

TAMMER SHIRLEY

19a. Informant's Name/Relationship (Type, Print)

LINDA MARTIN / DAUGHTER

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

4127 MINNESOTA AVE. NE WASHINGTON, DC 20019

20a. Method of Disposition

☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

HARMONY MEMORIAL PARK

Date

01/24/2004

20c. Location - City or Town, State

LARGO, MD

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

MARSHALL'S FUNERAL HOME OF MARYLAND, INC.
4308 SUITLAND ROAD SUITLAND, MD 20746

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. CARDIAC ARRHYTHMIA

Due to (or as a consequence of):

b. ATHEROSCLEROTIC HEART DISEASE

Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☒ No9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death4 ☐ Pregnant at time of death9 ☐ Unknown3 ☐ Ectopic pregnancy5 ☐ Other (specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes ☒ No

26. Place of Death (Check only one)

Hospital:

☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury

(Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

009565

29d. Date signed (Month, Day, Year)

1/20/04

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

EDGAR POTTER, M.D.

31 HOSPITAL DRIVE

CHEVERLY, MD

31. Date filed (Month, Day, Year)

JAN 22 2004

Registrar's Signature

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
ExaminerTo the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

1- For
State
Registrar

2004 03963

Physician
/Medical
ExaminerFuneral
Director

1. Decedent's Name (First, Middle, Last)

ROSARIO

VARGAS

2. Date of Death

Month

Day

Year

01

16, 2004

3. Time of Death

0930 AM

4a. Facility Name (If not institution, give street and number)

WASHINGTON ADVANTIST HOSPITAL

4b. City, Town, or Location of Death

TAKOMA PARK

4c. County of Death

MONTGOMERY

5. Social Security Number

220-82-7263

6. Sex

☐ M ☒ F

7. Age (In yrs. last birthday)

72

Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

SEPT. 16, 1931

9. Birthplace (State or Foreign Country)

ECUADOR

Usual Residence of Decedent

10a. State

MD.

10b. County

MONTGOMERY

10c. City, Town or Location

ROCKVILLE

10d. Inside City Limits

☒ Yes ☐ No

10e. Street and Number

4806 ASPEN HILL RD.

10f. Zip Code

20853

10g. Citizen of What Country?

U.S.A.

11. Marital Status

☒ Never Married ☐ Married☐ Widowed ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

☐ Yes ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

☒ Yes ☐ No

Specify:

ECUADORIAN

14. Race - American Indian, Black, White, etc.

Specify:

WHITE

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

6

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

HOMEMAKER

16b. Kind of Business/Industry

HOME

17. Father's Name (First, Middle, Last)

JOSE I. VARGAS

18. Mother's Name (First, Middle, Maiden Surname)

ROSA M. GARZON

19a. Informant's Name/Relationship (Type, Print)

DORA VARGAS/SISTER

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

4806 ASPEN HILL RD., ROCKVILLE, MD. 20853

20a. Method of Disposition

☒ Burial ☐ Cremation ☐ Removal from State☐ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

BASILICA NAT'L. SAGRADO

COROZON CEMETERY

Date

1-30-2004

20c. Location - City or Town, State

QUITO, ECUADOR

21. Signature of Funeral Service Licensee

W.D. Chambers

M00091

22. Name and Address of Facility

CHAMBERS FUNERAL HOME & CREMATORIUM, P.A.

5801 CLEVELAND AVE., RIVERDALE, MD. 20737

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. RESPIRATORY FAILURE

Due to (or as a consequence of):

b. ADULT RESPIRATORY DISTRESS SYNDROME

Due to (or as a consequence of):

c. MYOCARDIAL INFARCTION

Due to (or as a consequence of):

2 1/2 MONTHS

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

☐ Yes ☒ No☐ Unknown

23c. If yes, outcome of pregnancy

☐ Live birth ☐ Fetal death☐ Pregnant at time of death☐ Unknown☐ Ectopic pregnancy☐ Other (Specify)

23d. Date of delivery

Month

Day

Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23a. Did tobacco use contribute to the cause of death?

☐ Yes ☒ No ☐ Probably ☒ Unknown

24a. Was an autopsy performed?

☐ Yes ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

☐ Yes ☒ No

25. Was case referred to medical examiner?

☐ Yes ☒ No

26. Place of Death (Check only one)

Hospital:

☒ Inpatient☐ ER/Outpatient☐ DOA

Other:

☐ Nursing Home☐ Residence☐ Other (Specify)

27. Manner of Death

☒ Natural☐ Accident☐ Suicide☐ Homicide☐ Pending investigation☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

☐ Yes ☒ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Jonathan A. Calver MD

29c. License number

D50590

29d. Date signed (Month, Day, Year)

1/16/04

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

JONATHAN A. CALVER M.D., 7610 CARROLL AVE. #400, TAKOMA PARK, MD. 20912

31. Date filed (Month, Day, Year)

JAN 20 2004

32. Registrar's Signature

Benjamin B. Sparks

State
Registrar

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2004 03964

1- For
State
RegistrarPhysician
/Medical
ExaminerFuneral
Director

1. Decedent's Name (First, Middle, Last) <u>Viola Wong</u>		2. Date of Death Month <u>January</u> Day <u>19</u> Year <u>2004</u>		3. Time of Death <u>5:40A^M</u>	
4a. Facility Name (If not institution, give street and number) <u>Montgomery General Hospital</u>		4b. City, Town, or Location of Death <u>Olney</u>		4c. County of Death <u>Montgomery</u>	
5. Social Security Number <u>192-26-7224</u>	6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <u>100</u> Yrs.	8. Date of Birth (Month, Day, Year) <u>Dec 24, 1903</u>	9. Birthplace (State or Foreign Country) <u>California</u>	
10a. State <u>Maryland</u>		10b. County <u>Montgomery</u>		10c. City, Town or Location <u>Silver Spring</u>	
10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		10e. Street and Number <u>3330 N. Leisure World Blvd, #716</u>		10f. Zip Code <u>20906</u>	
10g. Citizen of What Country? <u>USA</u>		11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:	
13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <u>Asian</u>		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <u>2</u> College (1-4 or 5+) <u>2</u>	
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <u>Life Underwriter</u>		16b. Kind of Business/Industry <u>Insurance</u>		17. Father's Name (First, Middle, Last) <u>T. Wah Hing</u>	
18. Mother's Name (First, Middle, Maiden Surname) <u>Mon Song</u>		19a. Informant's Name/Relationship (Type, Print) <u>Geraldine Wong/Daughter</u>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>27050 Berkshire Dr, Southfield, MI 48076</u>	
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <u>East Lawn Cemetery</u>		20c. Location - City or Town, State <u>Jan 24, 2004 Sacramento, CA</u>	
21. Signature of Funeral Service Licensee <u>Alamy Daniel</u>		22. Name and Address of Facility <u>Hines-Rinaldi Funeral Home</u> <u>11800 New Hampshire Ave, Silver Spring, MD 20904</u>			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) <u>myocardial infarct</u> Due to (or as a consequence of): <u>congestive heart failure</u> Due to (or as a consequence of): <u>Anemia</u> Due to (or as a consequence of):		Approximate Interval Between Onset and Death <u>years</u> <u>years</u>		23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Unknown	
23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify)		23d. Date of delivery Month <u>January</u> Day <u>19</u> Year <u>2004</u>		23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown	
23f. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>intestinal obstruction</u> <u>hypertension</u>		24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined	
28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <u>M</u>		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)	
29a. Certifier (Check only one) 1 <input type="checkbox"/> Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier <u>Samuel G. Maller</u>		29c. License number <u>DS00612</u>	
29d. Date signed (Month, Day, Year) <u>January 19, 2004</u>		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <u>SAMUEL G. MALLER LEISURE WORLD MEDICAL CENTER Silver Spring Maryland</u>		31. Date filed (Month, Day, Year) <u>JAN 20 2004</u>	
32. Registrar's Signature <u>Benjamin B Sparks</u>					

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2004 03965

1- For
State
RegistrarPhysician
/Medical
ExaminerFuneral
Director

1. Decedent's Name (First, Middle, Last)

REVA L. WOLK

2. Date of Death
Month Day Year
JANUARY 11, 20043. Time of Death
1625 M

4a. Facility Name (If not institution, give street and number)

MONTGOMERY GENERAL HOSPITAL

4b. City, Town, or Location of Death

OLNEY

4c. County of Death

MONTGOMERY

5. Social Security Number

292-16-9891

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

85 Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

(Month, Day, Year)
09/21/1918

9. Birthplace (State or Foreign Country)

OHIO

Usual Residence of Decedent

10a. State

MARYLAND MONTGOMERY

10b. County

10c. City, Town or Location

SILVER SPRING

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

3310 N. LEISURE WORLD BLVD. #618

10f. Zip Code

20906

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

3

16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired)

HOMEMAKER

16b. Kind of Business/Industry

OWN HOME

17. Father's Name (First, Middle, Last)

LOUIS

LUPER

18. Mother's Name (First, Middle, Maiden Surname)

ROSE

ROSENBERG

19a. Informant's Name/Relationship (Type, Print)

STANLEY E. WOLK/SON

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

9701 FIELDS ROAD #1805, GAITHERSBURG, MD 20878

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

JUDEAN MEM. GARDENS

Date

01/13/2004

20c. Location - City or Town, State

OLNEY, MD

21. Signature of Funeral Service Licensee

Donald C. Stottumyer

22. Name and Address of Facility

DANZANSKY-GOLDBERG MEMORIAL CHAPELS, INC.
1170 ROCKVILLE PIKE, ROCKVILLE, MD 20852

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Acute Renal Failure

Due to (or as a consequence of):

b. Atherosclerotic Cardiovascular Disease

Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

> 9d

> 1yr

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☒ No
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death4 ☐ Pregnant at time of death9 ☐ Unknown3 ☐ Ectopic pregnancy5 ☐ Other (specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Chronic Obstructive Airway Disease
Aortic Stenosis
Pneumonia

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation
2 ☐ Accident 6 ☐ Could not be determined
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier
(Check only one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Donald C. Stottumyer

29c. License number

D050545

29d. Date signed (Month, Day, Year)

1/12/2004

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

GODEWILL O. OKOJI, MD

7512 New Hampshire Avenue
Takoma Park MD 20912

31. Date filed (Month, Day, Year)

JAN 20 2004

32. Registrar's Signature

Denise B. Sparks

State
Registrar

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2004 03366

1- For
State
RegistrarPhysician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

MARION S. WOLFSON

2. Date of Death
Month Day Year

JANUARY 8, 2004

3. Time of Death

9:30 P^MFuneral
Director

4a. Facility Name (If not institution, give street and number)

15301 WALLBROOK CT. #3F

4b. City, Town, or Location of Death

SILVER SPRING

4c. County of Death

MONTGOMERY

5. Social Security Number

011-08-8086

6. Sex

☐ M ☒ F

7. Age (In yrs. last birthday)

85 Yrs.

8. Date of Birth (Month, Day, Year)

06/14/1918

9. Birthplace (State or Foreign Country)

MAINE

Usual Residence of Decedent

10a. State

MARYLAND

10b. County

MONTGOMERY

10c. City, Town or Location

SILVER SPRING

10d. Inside City Limits

☒ Yes ☐ No

10e. Street and Number

15301 WALLBROOK CT. #3F

10f. Zip Code

20904

10g. Citizen of What Country?

U.S.A.

11. Marital Status

☐ Never Married ☐ Married
☒ Widowed ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

☐ Yes ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

☐ Yes ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)
12

College (1-4or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

SECRETARY

16b. Kind of Business/Industry

JEWISH COUNCIL
FOR AGING

17. Father's Name (First, Middle, Last)

JULIUS COHEN

18. Mother's Name (First, Middle, Maiden Surname)

DORA SAGOFSKI

19a. Informant's Name/Relationship (Type, Print)

JAY E. WOLFSON/SON

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

629A MAIN STREET, GAITHERSBURG, MARYLAND 20878

20a. Method of Disposition

☐ Burial ☒ Cremation ☐ Removal from State
☐ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

NATIONAL CREMATORY

Date

01/12/2004

20c. Location - City or Town, State

FALLS CHURCH, VIRGINIA

21. Signature of Funeral Service Licensee

Amanda Ludwig

22. Name and Address of Facility

EDWARD SAGEL FUNERAL DIRECTION, INC.
1091 ROCKVILLE PIKE, ROCKVILLE, MD 20852

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. BREAST CANCER

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death
YEARS

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

☐ Yes ☒ No
☐ Unknown

23c. If yes, outcome of pregnancy

☐ Live birth ☐ Fetal death ☐ Ectopic pregnancy
☐ Pregnant at time of death ☐ Other (specify)
☐ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

☐ Yes ☒ No ☐ Probably ☐ Unknown24a. Was an autopsy performed?
☐ Yes ☒ No24b. Were autopsy findings available prior to completion of cause of death?
☐ Yes ☒ No25. Was case referred to medical examiner?
☐ Yes ☒ No

Hospital:

☐ Inpatient ☐ ER/Outpatient ☐ DOA ☐ Other: ☐ Nursing Home ☒ Residence ☐ Other (Specify)

27. Manner of Death

☒ Natural ☐ Pending investigation
☐ Accident ☐ Suicide ☐ Homicide
☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?
☐ Yes ☒ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Chitra Rajagopal

29c. License number

D42452

29d. Date signed (Month, Day, Year)

JANUARY 12, 2004

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

CHITRA RAJAGOPAL, M.D., 18111 PRINCE PHILIP DR. #327, OLNEY, MD 20832

31. Date filed (Month, Day Year)

JAN 20 2004

32. Registrar's Signature

S. Sparks

State
Registrar

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

1- For
State
Registrar

2004 03967

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) John H. Wolfe				2. Date of Death Month Day Year January 17, 2004		3. Time of Death 2:35 PM	
	4a. Facility Name (If not institution, give street and number) Suburban Hospital				4b. City, Town, or Location of Death Bethesda		4c. County of Death Montgomery	
Funeral Director	5. Social Security Number 483-05-3375		6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		7. Age (In yrs. last birthday) 89 Yrs.		8. Date of Birth (Month, Day, Year) Feb. 19, 1914	
	9. Birthplace (State or Foreign Country) Iowa		10a. State Maryland		10b. County Montgomery		10c. City, Town or Location Chevy Chase	
To Be Completed by Funeral Director	10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		10e. Street and Number 5480 Wisconsin Avenue #825		10f. Zip Code 20815		10g. Citizen of What Country? United States	
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 10 College (1-4 or 5+) 10		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Manager		16b. Kind of Business/Industry Grocery Store			
	17. Father's Name (First, Middle, Last) Loren Wolfe				18. Mother's Name (First, Middle, Maiden Surname) Helena Doerning			
	19a. Informant's Name/Relationship (Type, Print) Pearl V. Wolfe/Wife				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5480 Wisconsin Ave., #825, Chevy Chase, Maryland 20815			
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Gate of Heaven Cemetery		20c. Location - City or Town, State Silver Spring, Maryland		20d. Date January 21, 2004	
	21. Signature of Funeral Service Licensee 		22. Name and Address of Facility Robert A. Pumphrey Funeral Home/Chase, Inc. 7557 Wisconsin Ave., Bethesda, MD 20814-3501					
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Intracranial Hemorrhage Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of):		23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) 9 <input type="checkbox"/> Unknown		23d. Date of delivery Month Day Year	
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown			
	24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No					
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)						
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		
28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) 2 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier Cristin Parker Howe MD		29c. License number D0059871		29d. Date signed (Month, Day, Year) January 18, 2004		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Cristin Parker Howe MD 9901 Medical Center Drive Rockville MD 20850								
31. Date filed (Month, Day, Year) JAN 20 2004		32. Registrar's Signature 						

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2004 03968

1- For State Registrar

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Physician /Medical Examiner

Funeral Director

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

1. Decedent's Name (First, Middle, Last) <i>Marilyn C. Winstead</i>		2. Date of Death Month <i>Jan</i> Day <i>16</i> Year <i>2004</i>		3. Time of Death <i>0835 M</i>	
4a. Facility Name (If not institution, give street and number) <i>114 Eldrid Dr</i>		4b. City, Town, or Location of Death <i>Silver Spring</i>		4c. County of Death <i>Montgomery</i>	
5. Social Security Number <i>182-34-2484</i>		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <i>61</i> Yrs.	
8. Date of Birth (Month, Day, Year) <i>10-17-42</i>		9. Birthplace (State or foreign Country) <i>PA</i>			
Usual Residence of Decedent					
10a. State <i>MD</i>		10b. County <i>Montgomery</i>		10c. City, Town or Location <i>Silver Spring</i>	
10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No					
10e. Street and Number <i>114 Eldrid Dr.</i>		10f. Zip Code <i>20904</i>		10g. Citizen of What Country? <i>U.S.A.</i>	
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:	
14. Race - American Indian, Black, White, etc. Specify: <i>White</i>		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <i>4</i> College (1-4or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <i>Analyst</i>	
16b. Kind of Business/Industry <i>N.S.A.</i>		17. Father's Name (First, Middle, Last) <i>Harry Crum</i>		18. Mother's Name (First, Middle, Maiden Surname) <i>Bernice Bitting</i>	
19a. Informant's Name/Relationship (Type, Print) <i>S. Dennis Winstead - Husband</i>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>20904 3404 Hampton Hollow Dr. Apt. A Silver Spring, MD</i>			
20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <i>Loundon Park Crem.</i>		20c. Location - City or Town, State <i>1-20-04 Baltimore, MD</i>	
21. Signature of Funeral Service Licensee <i>Alvane A. Capper</i>		22. Name and Address of Facility <i>Hines-Rinaldi F. H. 11800 New Hampshire Ave. Silver Spring, MD 20904</i>			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. <i>Probable myocardial infarction</i> Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Approximate Interval Between Onset and Death <i>DME</i>					
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 9 <input type="checkbox"/> Unknown 23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (Specify) 9 <input type="checkbox"/> Unknown 23d. Date of delivery Month Day Year					
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.					
23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown					
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No					
25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No 26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year) <i>M</i>		28b. Time of Injury <i>M</i>	
28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	
28f. Location (Street and Number or Rural Route Number, City or Town, State)					
29a. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.					
29b. Signature and title of certifier <i>IRA N BRECHER DME</i>		29c. License number <i>200428</i>		29d. Date signed (Month, Day, Year) <i>Jan 16, 2004</i>	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <i>IRA N BRECHER, MD DME Silver Spring MD 20903</i>					
31. Date filed (Month, Day, Year) <i>JAN 20 2004</i>		32. Registrar's Signature <i>Sparks</i>			

e 2004 03969

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2004 03970

1- For
State
Registrar

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Camilla S. Williams				2. Date of Death Month 01 Day 21 Year 2004		3. Time of Death 10:42pm	
	4a. Facility Name (If not institution, give street and number) Shady Grove Adventist Hospital				4b. City, Town, or Location of Death Rockville		4c. County of Death Montgomery	
Funeral Director	5. Social Security Number 258 64 5852	6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 66 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) 01/29/37		9. Birthplace (State or Foreign Country) Georgia
	Usual Residence of Decedent							
To Be Completed by Funeral Director	10a. State Md	10b. County Montgomery	10c. City, Town or Location Gaithersburg			10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		
	10e. Street and Number 405 Bostwick Lane			10f. Zip Code 20878		10g. Citizen of What Country? USA		
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: Black	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 1 #		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Supervisor		16b. Kind of Business/Industry Private			
To Be Completed by Physician/Medical Examiner	17. Father's Name (First, Middle, Last) Eddie Simmons				18. Mother's Name (First, Middle, Maiden Surname) Rose Bud Smith			
	19a. Informant's Name/Relationship (Type, Print) Husband Henry Lee Williams SR and				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 405 Bostwick Lane Gaithersburg, Md 20878			
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Fort Lincoln		Date 1/26/04		20c. Location - City or Town, State Brentwood, Md	
	21. Signature of Funeral Service Licensee Larry Inoué Sr.		22. Name and Address of Facility Snead Mortuary Service, P.A. 1409 Fairlakes Pl Ste B Mitchellville, Md					
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Metastatic poorly differentiated neuroendocrine carcinoma Due to (or as a consequence of): carcinoma							Approximate Interval Between Onset and Death 3 weeks
	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d.							
	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 9 <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 4 <input type="checkbox"/> Pregnant at time of death 9 <input type="checkbox"/> Unknown		3 <input type="checkbox"/> Ectopic pregnancy 5 <input type="checkbox"/> Other (specify)		23d. Date of delivery Month Day Year	
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown
To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28d. Describe how injury occurred					
	28f. Location (Street and Number or Rural Route Number, City or Town, State)							
State Registrar	29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
	29b. Signature and title of certifier Dr. A. Mendhiratta MD		29c. License number D38262		29d. Date signed (Month, Day, Year) Jan 22, 2004			
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DR A MENDHIRATTA 2401 Research Blvd Suite 330 Rockville MD 20850							
	31. Date filed (Month, Day, Year) JAN 23 2004		32. Registrar's Signature B. Sparks					

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2004 03971

1- For State Registrar

Physician /Medical Examiner

Funeral Director

1. Decedent's Name (First, Middle, Last) Mary Louise Wedderburn		2. Date of Death Month January Day 21 Year 2004		3. Time of Death 6:00 a M	
4a. Facility Name (If not institution, give street and number) Holy Cross Rehab. & Nursing Center		4b. City, Town, or Location of Death Burtonsville		4c. County of Death Montgomery	
5. Social Security Number 464-28-0900	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 91 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) Jan. 2, 1913
9. Birthplace (State or Foreign Country) Texas					
Usual Residence of Decedent					
10a. State Maryland	10b. County Prince George's	10c. City, Town or Location Laurel		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
10e. Street and Number 14004 Barkham Court		10f. Zip Code 20707		10g. Citizen of What Country? USA	
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:	
14. Race - American Indian, Black, White, etc. Specify: White					
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker		16b. Kind of Business/Industry Own Home	
17. Father's Name (First, Middle, Last) John Aguirre		18. Mother's Name (First, Middle, Maiden Surname) Emma South Peché			
19a. Informant's Name/Relationship (Type, Print) Peter Wedderburn/ Son		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 14004 Barkham Court, Laurel, MD 20707			
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Gate of Heaven Cemetery		20c. Location - City or Town, State January 24 2004 Silver Spring, MD	
21. Signature of Funeral Service Licensee 		22. Name and Address of Facility Francis J. Collins Funeral Home Inc. 500 University Blvd. W., Silver Spring, MD 20901			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Dementia Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Approximate Interval Between Onset and Death 5 years					
23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown					
23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <input type="checkbox"/> Unknown					
23d. Date of delivery Month Day Year					
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.					
23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown					
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M	
		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred	
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)	
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.					
29b. Signature and title of certifier 		29c. License number D43237		29d. Date signed (Month, Day, Year) January 22, 2004	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Paul Armstrong M.D. 14201 Laurel Park Drive, Suite 102, Laurel, MD 20707					
31. Date filed (Month, Day, Year) JAN 23 2004		32. Registrar's Signature 			

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0036
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 202-691-2058.

Physician /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2004 03972

1- For
State
RegistrarPhysician
/Medical
ExaminerFuneral
Director

1. Decedent's Name (First, Middle, Last)

Carl

Walton

Jr.

2. Date of Death

January 15, 2004

Day Year

3. Time of Death

6:15 a M

4a. Facility Name (If not institution, give street and number)

4209 Bar Harbor Place

4b. City, Town, or Location of Death

Olney

4c. County of Death

Montgomery

5. Social Security Number

722-16-3486

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

75

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Dec. 15, 1928

9. Birthplace (State or Foreign Country)

Indiana

Usual Residence of Decedent

10a. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Olney

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

4209 Bar Harbor Place

10f. Zip Code

20832

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☒ Yes 2 ☐ No

If Yes, Give Year or Dates: 1945 -

1955

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: White

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

8

College (1-4 or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

Restaurant Manager

16b. Kind of Business/Industry

Food and Beverage

17. Father's Name (First, Middle, Last)

Carl Walton Sr.

18. Mother's Name (First, Middle, Maiden Surname)

Arzella Mae Boots

19a. Informant's Name/Relationship (Type, Print)

Deborah Walton/Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

4209 Bar Harbor Place, Olney, MD 20832

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Gate of Heaven

Cemetery

Date

January 19

2004

20c. Location - City or Town, State

Silver Spring, MD

21. Signature of Funeral Service Licensee

J. Ken Stole

22. Name and Address of Facility

Francis J. Collins Funeral Home Inc.

500 University Blvd. W., Silver Spring, MD 20901

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Colon Cancer

a. Due to (or as a consequence of):

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

1 year

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☐ No9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death4 ☐ Pregnant at time of death9 ☐ Unknown3 ☐ Ectopic pregnancy5 ☐ Other (specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☒ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury

(Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

29a. Certifier

(Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D45880

29d. Date signed (Month, Day, Year)

January 16, 2004

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Leon C. Hwang M.D.

1396 Piccard Drive, Rockville, MD 20850

31. Date filed (Month, Day, Year)

JAN 20 2004

32. Registrar's Signature

State
Registrar

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2004 03973

1- For
State
Registrar

Physician
/Medical
Examiner

Funeral
Director

1. Decedent's Name (First, Middle, Last)

Kenneth C. Williams, Sr.

2. Date of Death

Month Day Year
January 18, 2004

3. Time of Death

5:35 PM

4a. Facility Name (If not institution, give street and number)

2104 County Road Apt. 101

4b. City, Town, or Location of Death

District Heights

4c. County of Death

Prince George's

5. Social Security Number

238-82-7280

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

53 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
Mar. 5, 1950

9. Birthplace (State or Foreign Country)

No. Carolina

Usual Residence of Decedent

10a. State

Md.

10b. County

Prince Georges

10c. City, Town or Location

Clinton

10d. Inside City Limits

☒ Yes ☐ No

10e. Street and Number

8604 Woodyard Road

10f. Zip Code

20735

10g. Citizen of What Country?

USA

11. Marital Status

☐ Never Married ☐ Married
☐ Widowed ☒ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
☐ Yes ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

☐ Yes ☒ No Specify:

14. Race - American Indian,
Black, White, etc.

Specify: Black

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Laborer

16b. Kind of Business/Industry

County Government

17. Father's Name (First, Middle, Last)

George T. Williams

18. Mother's Name (First, Middle, Maiden Surname)

Ann Barrett

19a. Informant's Name/Relationship (Type, Print) (Son)

Kenneth C. Williams, Jr.

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

801 Ashley Lane
Stone Mountain, Georgia 30087

20a. Method of Disposition

☒ Burial ☐ Cremation ☐ Removal from State
☐ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of
cemetery, crematory or other place)

Zachariah Church Cem

Date

1/25/04

20c. Location - City or Town, State

Walstonburg, N.C.

21. Signature of Funeral Service Licensee

Ralph Williams 767

22. Name and Address of Facility

Ralph Williams Funeral Service
1813 Potomac Ave., SE; Wash., D.C. 20003

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest.
shock, or heart failure. List only one cause on each line.

Immediate Cause (Final
disease or condition
resulting in death)

a. Hypertensive Atherosclerotic Cardiovascular Disease

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate
Interval Between
Onset and Death

IF FEMALE:

23b. Was decedent pregnant
in the past 12 months?

☐ Yes ☐ No
☒ Unknown

23c. If yes, outcome of pregnancy

☐ Live birth ☐ Fetal death ☐ Ectopic pregnancy
☐ Pregnant at time of death ☐ Other (specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Fatty liver, chronic alcoholism

23e. Did tobacco use contribute to the cause of death?

☐ Yes ☐ No ☐ Probably ☒ Unknown

24a. Was an
autopsy
performed?
☒ Yes ☐ No

24b. Were autopsy findings available
prior to completion of cause of
death?
☒ Yes ☐ No

25. Was case referred to medical
examiner?
☒ Yes ☐ No

Hospital:

☐ Inpatient ☐ ER/Outpatient ☐ DOA

26. Place of Death (Check only one)

Other: ☐ Nursing Home ☐ Residence ☒ Other (Specify) At scene

27. Manner of Death

☒ Natural ☐ Pending investigation
☐ Accident ☐ Could not be determined
☐ Suicide ☐ Homicide

28a. Date of Injury

(Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

☐ Yes ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number,
City or Town, State)

29a. Certifier
(Check only
one)

☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Theodore M. King

29c. License number

O.C.M.E.

29d. Date signed (Month, Day, Year)

January 19, 2004

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

THEODORE M. King

111 Penn Street, Baltimore, Maryland 21201

31. Date filed (Month, Day, Year)

JAN 22 2004

32. Registrar's Signature

John A. Smith

State
Registrar

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or item 23a or 28a-f show
any injury or other traumatic event, the Medical Examiner must be notified at
once.

Physician
/Medical
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2004 03974

1- For
State
RegistrarPhysician
/Medical
ExaminerFuneral
Director

1. Decedent's Name (First, Middle, Last)

MILLICENT

WALKER

2. Date of Death

1 9

Day
2004

Year

3. Time of Death

8:00 P M

4a. Facility Name (If not institution, give street and number)

MAGNOLIA CENTER

4b. City, Town, or Location of Death

LANHAM

4c. County of Death

PRINCE GEORGE'S

5. Social Security Number

213-21-5977

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

92

Yrs.

If Under 1 Year

Months

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

(Month, Day, Year)

8 16

1911

9. Birthplace (State or Foreign Country)

Guyana

Usual Residence of Decedent

10a. State

MD

10b. County

PRINCE GEORGE'S

10c. City, Town or Location

HYATTSVILLE

10d. Inside City Limits

☒ Yes 2 ☐ No

10e. Street and Number

2705 KIRKWOOD PLACE # 101

10f. Zip Code

20782

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☒ Never Married 2 ☐ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: Black

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12th

College (1-4or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working

life. DO NOT use retired)

Typesetter

16b. Kind of Business/Industry

Private

17. Father's Name (First, Middle, Last)

George Walker

18. Mother's Name (First, Middle, Maiden Surname)

Rosaline Jones

19a. Informant's Name/Relationship (Type, Print)

Leslie Telford/Nephew

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

4407 Saddle River Drive Bowie, Maryland 20720

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Riverdale Crematory

Date

1-19-2004

20c. Location - City or Town, State

Riverdale, Maryland

21. Signature of Funeral Service Licensee

K. D. Marshall

22. Name and Address of Facility J. B. JENKINS FUNERAL HOME

7474 LANDOVER ROAD LANDOVER, MARYLAND 20785

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Carcinoma of the Rectum

Due to (or as a consequence of):

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☐ No9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death4 ☐ Pregnant at time of death9 ☐ Unknown3 ☐ Ectopic pregnancy5 ☐ Other (specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury

(Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier
(Check only one)1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Dr. Don Yablonowitz

29c. License number

D25071

29d. Date signed (Month, Day, Year)

1-15-04

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Dr. Don Yablonowitz 7404 Executive Place # 502 Lanham, Maryland 20706

31. Date filed (Month, Day, Year)

JAN 21 2004

32. Registrar's Signature

Don Yablonowitz

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2004 03975

- 1 - For State Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) John H. White				2. Date of Death Month January Day 14 , Year 2004		3. Time of Death 1:41p. M	
	4a. Facility Name (If not institution, give street and number) Washington Adventist Hospital				4b. City, Town, or Location of Death Takoma Park		4c. County of Death Montgomery	
Funeral Director	5. Social Security Number 226 18 4501		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 83 Yrs.		8. Date of Birth (Month, Day, Year) June 9, 1920	
	9. Birthplace (State or Foreign Country) Virginia		10a. State D.C.		10b. County Washington		10c. City, Town or Location Washington	
To Be Completed by Funeral Director	10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		10e. Street and Number 314 34th Place, N.E.		10f. Zip Code 20019		10g. Citizen of What Country? USA	
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: Black	
To Be Completed by Physician/Medical Examiner	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 years		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Protective Officer		16b. Kind of Business/Industry Government			
	17. Father's Name (First, Middle, Last) Benjamin White, Sr.		18. Mother's Name (First, Middle, Maiden Surname) Myrtle (Unknown)		19a. Informant's Name/Relationship (Type, Print) Dorothy Mitchell / Niece		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4231 Nash St., N.E. Washington, D.C. 20020	
Physician /Medical Examiner	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Mt. Olivet Cem.		Date 1/17/2004		20c. Location - City or Town, State Wash., D.C.	
	21. Signature of Funeral Service Licensee 		22. Name and Address of Facility John T. Rhines Funeral Home 3015 12th Street, N.E. Wash., D.C. 20017		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Septic Shock Respiratory Failure		Approximate Interval Between Onset and Death	
To Be Completed by Physician/Medical Examiner	23b. Part II. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. End Stage Renal Failure Infected Left Foot, HTW Diabetes Mellitus		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Unknown		23d. Date of delivery Month 1 Day 15 Year 2004		23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown	
	24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)	
State Registrar	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year) 1/17/2004		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
State Registrar	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier 		29c. License number D45471		29d. Date signed (Month, Day, Year) 01/15/2004	
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Negussie Washington Adventist Hospital		31. Date filed (Month, Day, Year) JAN 21 2004		32. Registrar's Signature 			

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2004 03976

1- For State Registrar

Physician /Medical Examiner

Funeral Director

1. Decedent's Name (First, Middle, Last) TORRIS Willis		2. Date of Death Month January Day 14 Year 2004		3. Time of Death 5:00 PM
4a. Facility Name (If not institution, give street and number) WOODSIDE NURSING Center		4b. City, Town, or Location of Death Silver Spring		4c. County of Death Montgomery
5. Social Security Number 254-30-6512	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 78 Yrs.	8. Date of Birth (Month, Day, Year) 3-10-25	9. Birthplace (State or Foreign Country) Georgia

Usual Residence of Decedent		10c. City, Town or Location Washington, DC		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
10a. State DC	10b. County	10e. Street and Number 3601 28th St., NE		10f. Zip Code 20018
10g. Citizen of What Country? United States				

11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: African American	
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15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12th College (14 or 5+) 4 years		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Park Police / Bus Driver		16b. Kind of Business/Industry US GOVERNMENT METRO	
--	--	--	--	--	--

17. Father's Name (First, Middle, Last) Willie Willis		18. Mother's Name (First, Middle, Maiden Surname) Maggie Cunningham	
---	--	---	--

19a. Informant's Name/Relationship (Type, Print) Tannette Willis - wife		19b. Mailing Address (Street and Number of Rural Route Number, City or Town, State, Zip Code) 3601 28th St., NE Washington DC 20018	
---	--	---	--

20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Quantico National Cem.		20c. Location - City or Town, State Triangle, VA	
---	--	---	--	--	--

21. Signature of Funeral Service Licensee [Signature]		22. Name and Address of Facility JOHN T. Rhines Funeral Home 3015 12th St., NE Washington DC 20017	
---	--	--	--

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Failure to thrive		Approximate Interval Between Onset and Death 1 year	
--	--	---	--

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dementia		Due to (or as a consequence of): far yrs	
---	--	--	--

Due to (or as a consequence of):			
----------------------------------	--	--	--

Due to (or as a consequence of):			
----------------------------------	--	--	--

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <input type="checkbox"/> Unknown		23d. Date of delivery Month Day Year	
---	--	---	--	---	--

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown	
--	--	---	--

24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
---	--	--	--

25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)	
---	--	---	--

27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred	
--	--	---------------------------------------	--	---------------------------------	--	---	--	-----------------------------------	--

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)	
--	--	--	--

29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier [Signature]		29c. License number D38262		29d. Date signed (Month, Day, Year) January 15, 2004	
---	--	---	--	--------------------------------------	--	--	--

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DRA MENDHIRATTA 2401 Research BLVD Suite 330 Rockville MD 20850	
--	--

31. Date filed (Month, Day, Year) JAN 21 2004		32. Registrar's Signature [Signature]	
---	--	---	--

State Registrar

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification; To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2004 03977

1- For State Registrar

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

1. Decedent's Name (First, Middle, Last) <u>Catherine Wood</u>		2. Date of Death Month <u>Jan</u> Day <u>14</u> Year <u>2004</u>		3. Time of Death <u>7:30 PM</u>	
4a. Facility Name (If not institution, give street and number) <u>Prince Georges Hosp Center</u>		4b. City, Town, or Location of Death <u>Chesery</u>		4c. County of Death <u>PG</u>	
5. Social Security Number <u>578-48-4099</u>		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <u>87</u> Yrs.	
8. Date of Birth (Month, Day, Year) <u>July 6, 1916</u>		9. Birthplace (State or Foreign Country) <u>Maryland</u>			
10a. State <u>MD</u>		10b. County <u>Prince George</u>		10c. City, Town or Location <u>Forestville</u>	
10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		10e. Street and Number <u>7205 Cross Street</u>		10f. Zip Code <u>20747</u>	
10g. Citizen of What Country? <u>USA</u>		11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:	
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <u>Black</u>			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <u>12th</u> College (1-4or 5+) <u></u>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <u>Homemaker</u>		16b. Kind of Business/Industry <u>Domestic</u>	
17. Father's Name (First, Middle, Last) <u>Andrew Matthews</u>		18. Mother's Name (First, Middle, Maiden Surname) <u>Linnie Chase</u>			
19a. Informant's Name/Relationship (Type, Print) <u>Shirley Wood/Daughter</u>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>7205 Cross St, Forestville, MD 20747</u>			
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <u>Cedar Hill</u>		20c. Location - City or Town, State <u>Suitland, MD</u>	
21. Signature of Funeral Service Licensee <u>[Signature]</u>		22. Name and Address of Facility <u>Strickland Funeral Services</u> <u>6500 Allentown Rd, Camp Springs, MD 20748</u>			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. <u>SEPTIC SHOCK</u> Due to (or as a consequence of): b. <u></u> Due to (or as a consequence of): c. <u></u> Due to (or as a consequence of): d. <u></u> Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		23b. IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 9 <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (Specify) 9 <input type="checkbox"/> Unknown	
23d. Date of delivery Month <u></u> Day <u></u> Year <u></u>		23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown		24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)	
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year) <u></u>		28b. Time of Injury <u>M</u>	
28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred <u></u>		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) <u></u>	
28f. Location (Street and Number or Rural Route Number, City or Town, State) <u></u>		29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier <u>[Signature]</u>	
29c. License number <u>D-055220</u>		29d. Date signed (Month, Day, Year) <u>1/14/04</u>		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <u>3001 Hospital Drive, Chesery MD 20785</u>	
31. Date filed (Month, Day, Year) <u>JAN 20 2004</u>		Registrar's Signature <u>[Signature]</u>			

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2004 03978

1- For State Registrar

Physician / Medical Examiner
Funeral Director

1. Decedent's Name (First, Middle, Last) SHIRLEY BOLDEN WHITEMAN				2. Date of Death Month January Day 15 Year 2004		3. Time of Death 1:16 P^M	
4a. Facility Name (If not institution, give street and number) Holy Cross Hospital				4b. City, Town, or Location of Death Silver Spring		4c. County of Death Montgomery	
5. Social Security Number 038-09-2388		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 94 Yrs.		8. Date of Birth (Month, Day, Year) Oct. 12, 1909	
9. Birthplace (State or Foreign Country) Providence, RI							
Usual Residence of Decedent							
10a. State Maryland		10b. County Prince George's		10c. City, Town or Location Fort Washington		10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No	
10e. Street and Number 2311 Rosecroft Blvd.				10f. Zip Code 20744		10g. Citizen of What Country? U.S.A.	
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: Black	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12th College (1-4 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Computer Aide		16b. Kind of Business/Industry Federal Government	
17. Father's Name (First, Middle, Last) Dennis K. Bolden				18. Mother's Name (First, Middle, Maiden Surname) Carrie T. Tilghman			
19a. Informant's Name/Relationship (Type, Print) Ernest W. Huggs, Jr./Son				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2311 Rosecroft Blvd., Fort Washington, MD 20744			
20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input checked="" type="checkbox"/> Other (Specify) Entombment		20b. Place of Disposition (Name of cemetery, crematory or other place) Mausoleum Fort Lincoln Cemetery		Date 1/22/2004		20c. Location - City or Town, State Brentwood, Maryland	
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility FORT LINCOLN FUNERAL HOME 3401 Bladensburg Road, Brentwood, Maryland 20722			

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician / Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Respiratory Arrest Due to (or as a consequence of): b. Pneumonia Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last				Approximate Interval Between Onset and Death	
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 9 <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) _____ 9 <input type="checkbox"/> Unknown		23d. Date of delivery Month _____ Day _____ Year _____	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown	
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death Check only one Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) _____			
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year) 28b. Time of Injury M 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State)	
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier 		29c. License number D-52261	
29d. Date signed (Month, Day, Year) January 15, 2004					
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Alan R. Segal, M.D., 1500 Forest Glen Road, Silver Spring, Maryland 20910					
31. Date filed (Month, Day, Year) JAN 20 2004		32. Registrar's Signature 			

Medical Certification; To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

CR (5)

State Registrar

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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2004 03979

1- For
State
RegistrarPhysician
/Medical
ExaminerFuneral
Director

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

1. Decedent's Name (First, Middle, Last) MARLENE WINN		2. Date of Death Month Day Year January 11, 2004		3. Time of Death 23:23 P M	
4a. Facility Name (If not institution, give street and number) SOUTHERN MARYLAND HOSPITAL		4b. City, Town, or Location of Death CLINTON		4c. County of Death PRINCE GEORGE'S	
5. Social Security Number 577-52-4702	6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 65 Yrs.	8. Date of Birth (Month, Day, Year) June 6, 1938	9. Birthplace (State or Foreign Country) Wash., D.C.	
Usual Residence of Decedent					
10a. State Maryland	10b. County Prince George's	10c. City, Town or Location Oxon Hill		10d. Inside City Limits <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No	
10e. Street and Number 4904 Glassmanor Drive		10f. Zip Code 20745		10g. Citizen of What Country? USA	
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:	
14. Race - American Indian, Black, White, etc. Specify: BLACK		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12th College (1-4 or 5+)			
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Computer Supervisor		16b. Kind of Business/Industry Federal Government			
17. Father's Name (First, Middle, Last) Clarence Cunningham			18. Mother's Name (First, Middle, Maiden Surname) Vernell Minor		
19a. Informant's Name/Relationship (Type, Print) Nathaniel Winn/husband		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4904 Glassmanor Dr. Oxon Hill, Md. 20745			
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Washington Nat'l Cem.		20c. Location - City or Town, State Suitland, Md.	
21. Signature of Funeral Service Licensee <i>W. G. Jefferson</i>		22. Name and Address of Facility Frazier's Funeral Home, Inc. 389 R.I. Ave., N.W. Wash., DC 20001			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Septicemia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last a. Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d.					
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 9 <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) 9 <input type="checkbox"/> Unknown		23d. Date of delivery Month Day Year	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Acute Respiratory Distress Syndrome End Stage Renal Disease Hemodialysis Dependent				23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown	
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M	
28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		28d. Describe how injury occurred			
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.					
29b. Signature and title of certifier <i>Palmer MD</i>		29c. License number 00055120		29d. Date signed (Month, Day, Year) Jan 12 2004	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Richard Palmer MD 1328 Southern Ave SE Suite 310 Washington DC 20032					
31. Date filed (Month, Day, Year) JAN 22 2004		32. Registrar's Signature <i>Adam & Apple</i>			

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

State
Registrar

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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

1- For State Registrar

2004 03980

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Therese Yarborough				2. Date of Death Month Day Year January 18, 2004		3. Time of Death 11:18A M	
	4a. Facility Name (If not institution, give street and number) Southern Maryland Hospital				4b. City, Town, or Location of Death Clinton		4c. County of Death Prince George	
Funeral Director	5. Social Security Number 231-56-2100		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 74 Yrs.		8. Date of Birth (Month, Day, Year) May 22, 1929	
	9. Birthplace (State or Foreign Country) Germany		10a. State Maryland		10b. County Prince George		10c. City, Town or Location Capitol Heights	
To Be Completed by Funeral Director	10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		10e. Street and Number 1107 Mentor Avenue		10f. Zip Code 20743		10g. Citizen of What Country? United States	
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker		16b. Kind of Business/Industry Private			
	17. Father's Name (First, Middle, Last) Martin Muller				18. Mother's Name (First, Middle, Maiden Surname) Elisa Weinz			
	19a. Informant's Name/Relationship (Type, Print) Albert Carl Yarborough/Spouse				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1107 Mentor Avenue, Capitol Heights, MD. 20743			
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Maryland Veterans Cem.		Date Jan. 23, 2004		20c. Location - City or Town, State Cheltenham, MD.	
	21. Signature of Funeral Service Licensee <i>[Signature]</i>		22. Name and Address of Facility Pope Funeral Homes 5538 Marlboro Pike Forestville, MD. 20747					
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Myelo/lympho proliferative Disease Due to (or as a consequence of): b. Disseminating Intravascular Coagulation Due to (or as a consequence of): c. Liver Failure Due to (or as a consequence of): d. Respiratory Failure		23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify)		23d. Date of delivery Month Day Year	
	23e. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Septic Splanchnopathy		23f. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown		23g. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		23h. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year) M	
28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		
28f. Location (Street and Number or Rural Route Number, City or Town, State)		29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier <i>[Signature]</i>		29c. License number D34140		
29d. Date signed (Month, Day, Year) 1/21/2004		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3261 Old Washington Rd #1012 Waldorf, Md. 20602		31. Date filed (Month, Day, Year) JAN 21 2004		32. Registrar's Signature <i>[Signature]</i>		

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

State Registrar

DHMH 17 Rev 1/2001

ORIGINAL

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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2004 03981

1- For
State
RegistrarPhysician
/Medical
ExaminerFuneral
Director

1. Decedent's Name (First, Middle, Last)

Jack Young

2. Date of Death

Month Day Year

Jan. 18 2004

3. Time of Death

6:15 P M

4a. Facility Name (If not institution, give street and number)

Charlotte Hall Retirement Home

4b. City, Town, or Location of Death

Charlotte Hall

4c. County of Death

St. Marys

5. Social Security Number

343-16-5267

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

88

8. Date of Birth

Month Day Year

Oct. 11, 1915

9. Birthplace (State or Foreign Country)

Texas

Usual Residence of Decedent

10a. State

Maryland

10b. County

St. Marys

10c. City, Town or Location

Charlotte Hall

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

29449 Charlotte Hall Road

10f. Zip Code

20622

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☒ Yes 2 ☐ No

If Yes, Give Year or Dates: 1941-46

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: White

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

4

16a. Decedent's Usual Occupation

(Give kind of work done during most of working life. DO NOT use retired)

Lieutenant Colonel

16b. Kind of Business/Industry

U.S. Army

17. Father's Name (First, Middle, Last)

Henry D. Young

18. Mother's Name (First, Middle, Maiden Surname)

Grace Murrell

19a. Informant's Name/Relationship (Type, Print)

Virginia Reynolds-Sister

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

3404 American Dr., Villa 1107, Lago Vista, Tx., 78645

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Arlington National

Date

Jan. 30, 2004

20c. Location - City or Town, State

Arlington, Va.

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Murphy Funeral Homes, Inc.

4510 Wilson Blvd., Arlington, Va. 22203

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or other failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. MYOCARDIAL INFARCTION

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☐ No9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death4 ☐ Pregnant at time of death9 ☐ Unknown3 ☐ Ectopic pregnancy5 ☐ Other (specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Atrial Fibrillation, Hypertension,

Cerebrovascular Accident, Peripheral Vascular Disease, Above the Knee Amputation, Seizure Disorder

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ OOA

26. Place of Death (Check only one)

Other: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury

(Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier

(Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number

D 50763

29d. Date signed (Month, Day, Year)

01/19/04

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

PULTON WILKINSON M.D., CHAIR, CHARLOTTE HALL, MD

31. Date filed (Month, Day, Year)

JAN 22 2004

32. Registrar's Signature

State Registrar

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permitted. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "Natural", or item 23a or 23e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For
State
Registrar

Amend Item #26 per VERBAL 8282/11/04

Certificate of Death

Reg. No.

2004 03982

Physician
/Medical
ExaminerFuneral
Director

1. Decedent's Name (First, Middle, Last) Isadore ABRAMS		2. Date of Death Month Day Year January 30, 2004		3. Time of Death 8:05 P M	
4a. Facility Name (If not institution, give street and number) Shady Grove Adventist Hospital		4b. City, Town, or Location of Death Rockville		4c. County of Death Montgomery	
5. Social Security Number 186-05-7104	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 86 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) Sept. 5, 1917
9. Birthplace (State or Foreign Country) Philadelphia, PA					
Usual Residence of Decedent					
10a. State MD	10b. County Montgomery	10c. City, Town or Location Rockville		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
10e. Street and Number 14431 Traville Garden		10f. Zip Code 20850		10g. Citizen of What Country? U.S.A.	
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: WWII		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:	
14. Race - American Indian, Black, White, etc. Specify: White					
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Scrap Metal Dealer		16b. Kind of Business/Industry Metals	
17. Father's Name (First, Middle, Last) Max Abrams		18. Mother's Name (First, Middle, Maiden Surname) Fannie Prince			
19a. Informant's Name/Relationship (Type, Print) Ruth Abrams spouse		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 14431 Traville Garden, Rockville, MD 20850			
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Mt. Sharon Cemetery		20c. Location - City or Town, State Philadelphia, PA	
21. Signature of Funeral Service Licensee 		22. Name and Address of Facility Torchinsky Hebrew Funeral Home, Inc. 254 Carroll St. NW Washington, DC 20012			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sepsis Due to (or as a consequence of): Catheter infection Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Unknown Unknown					
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <input type="checkbox"/> Unknown		23d. Date of delivery Month Day Year	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. End stage cardiomyopathy				23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown	
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M	
28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred			
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.					
29b. Signature and title of certifier  Cristin Parker Howe MD		29c. License number 00059871		29d. Date signed (Month, Day, Year) January 31, 2004	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Cristin Parker Howe MD 9901 medical center Drive Rockville, MD 20850					
31. Date filed (Month, Day, Year) FEB 11 2004		32. Registrar's Signature 			

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2004 03983

1- For
State
RegistrarPhysician
/Medical
ExaminerFuneral
Director

1. Decedent's Name (First, Middle, Last)

Luella Ahner

2. Date of Death

2 9 2004

3. Time of Death

1056A^M

4a. Facility Name (If not institution, give street and number)

University of Maryland

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

5. Social Security Number

274-14-7872

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

83

Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth (Month, Day, Year)

Aug. 16, 1920

9. Birthplace (State or Foreign Country)

Ohio

Usual Residence of Decedent

10a. State

MD

10b. County

Anne Arundel

10c. City, Town or Location

Odenton

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

2150 Colonel Way

10f. Zip Code

21113

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

William J.

Miesle

18. Mother's Name (First, Middle, Maiden Surname)

Claire

Bunschew

19a. Informant's Name/Relationship (Type, Print)

Mary Lou Lowry Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2150 Colonel Way Odenton, MD 21113

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Metro Crematory

Date

2-11-04

20c. Location - City or Town, State

Baltimore, MD

21. Signature of Funeral Service Licensee

Babal J. Adell

22. Name and Address of Facility

Hardesty Funeral Home P.A. 12 Ridgely Ave
Ann, MD 21401

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. HEMOTHORAX (Right)

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☒ No
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy
4 ☐ Pregnant at time of death 5 ☐ Other (specify)
9 ☐ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Myocardial infarction

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Babal J. Adell MD

29c. License number

AU4176435515150

29d. Date signed (Month, Day, Year)

FEBRUARY 9, 2004

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

22 SOUTH GREENE BALTIMORE, MD 21201

31. Date filed (Month, Day, Year)

FEB 11 2004

32. Registrar's Signature

Babal J. Adell

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2004 03984

1- For
State
Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Clifford Nathaniel Burrows		2. Date of Death Month Day Year February 6 2004		3. Time of Death 3:05 P M
	4a. Facility Name (If not institution, give street and number) 821 North Avondale Road		4b. City, Town, or Location of Death Dundalk		4c. County of Death Baltimore
Funeral Director	5. Social Security Number 212-14-1047	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 82 Yrs.	8. Date of Birth (Month, Day, Year) May 1, 1921	
	9. Birthplace (State or Foreign Country) Maryland				
To Be Completed by Funeral Director	10a. State Maryland		10b. County Baltimore		10c. City, Town or Location Dundalk
	10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				
	10e. Street and Number 821 North Avondale Road		10f. Zip Code 21222		10g. Citizen of What Country? United States
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:
	14. Race - American Indian, Black, White, etc. Specify: Black				
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 6 College (1-4or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Steel Worker		16b. Kind of Business/Industry Bethlehem Steel
	17. Father's Name (First, Middle, Last) Major Burrows		18. Mother's Name (First, Middle, Maiden Surname) Maud Gaines		
	19a. Informant's Name/Relationship (Type, Print) Everett H. Burrows - Son		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 114 Glenard Middleton Court Dundalk, Maryland 21222		
	20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Balt. Wash. Crematory		20c. Location - City or Town, State Laurel, Maryland
	21. Signature of Funeral Service Licensee <i>[Signature]</i> MD1142		22. Name and Address of Facility Bradley-Ashton-Matthews Funeral Home, Inc. 2134 Willow Spring Road Dundalk, Maryland 21222		
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Metastatic prostate cancer					
23b. Part II. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. ① Hypertension ② advanced BTD					
23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify)					
23d. Date of delivery Month Day Year					
23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown					
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
26. Place of Death Check only one Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> OOA Other: <input checked="" type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) Home					
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined					
28a. Date of Injury (Month, Day Year) NA 28b. Time of Injury NA M 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
28d. Describe how injury occurred NA					
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)					
28f. Location (Street and Number or Rural Route Number, City or Town, State)					
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.					
29b. Signature and title of certifier <i>[Signature]</i> MD1142					
29c. License number D57061					
29d. Date signed (Month, Day, Year) 2/9/04					
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MUHAMMAD M. RANA, MD 4920-CAMPBELL BLVD, BALTI MD 21238					
31. Date filed (Month, Day, Year) FEB 11 2004					
32. Registrar's Signature <i>[Signature]</i>					

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural" or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2004 03985

1- For
State
RegistrarPhysician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Mildred Elaine Barbee

2. Date of Death

February 8 2004

3. Time of Death

10:40 A M

Funeral
Director

4a. Facility Name (If not institution, give street and number)

Chesapeake Hospice House

4b. City, Town, or Location of Death

Linthicum

4c. County of Death

Anne Arundel

5. Social Security Number

212-20-4821

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

80 Yrs.

If Under 1 Year

Months

If Under 24 Hrs.

Hours

8. Date of Birth

May 11, 1923

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

MD

10b. County

Anne Arundel

10c. City, Town or Location

Glen Burnie

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

8051 Winding Woods Rd

10f. Zip Code

21061

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Book Keeper

16b. Kind of Business/Industry

Furniture Store

17. Father's Name (First, Middle, Last)

Robert Merryman

18. Mother's Name (First, Middle, Maiden Surname)

Unknown

19a. Informant's Name/Relationship (Type, Print)

Eugene A. Barbee Husband

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

8051 Winding Woods Rd., Glen Burnie, MD 21061

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Bayview Crematory, Inc. 2-9-2004 Baltimore, MD

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Ambrose Funeral Home, Inc.
1328 Sulphur Spring Rd., Arbutus, MD 21227

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. CARCINOMA OF LUNG

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

2 Years

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☒ No
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy
4 ☐ Pregnant at time of death 5 ☐ Other (specify)
9 ☐ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

PERIPHERAL VASCULAR DISEASE

23e. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☒ Other (Specify) HOSPICE HOUSE

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation
2 ☐ Accident 6 ☐ Could not be determined
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D216841

29d. Date signed (Month, Day, Year)

02/09/2004

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

C. V. CYRIAC-M.O., 8021 RITCHIE HWY, PASADENA, MD 21122

31. Date filed (Month, Day, Year)

FEB 11 2004

32. Registrar's Signature

Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural," or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 5053.

Physician
/Medical
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

1- For State Registrar

2004 03986

Patient Known as: Barnett Berman

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial/transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) BARNETT Berman		2. Date of Death Month February Day 6 Year 2004		3. Time of Death 6:25 PM
	4a. Facility Name (If not institution, give street and number) Sinai Hospital of Baltimore		4b. City, Town, or Location of Death Baltimore City		4c. County of Death N/A
Funeral Director	5. Social Security Number 215-16-7424	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 81 Yrs.	8. Date of Birth (Month, Day, Year) AUG. 8, 1922	
	9. Birthplace (State or Foreign Country) MD		10. Usual Residence of Decedent		
10a. State MD		10b. County BALTIMORE	10c. City, Town or Location BALTIMORE		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
10e. Street and Number 3119 NORTHBROOK ROAD		10f. Zip Code 21208		10g. Citizen of What Country? U.S.A.	
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No WWII If Yes, Give Year or Dates: KOREA		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:	
14. Race - American Indian, Black, White, etc. Specify: WHITE		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 5+ College (1-4 or 5+) INTERDIST		16. Kind of Business/Industry MEDICINE	
17. Father's Name (First, Middle, Last) BENJAMIN Berman		18. Mother's Name (First, Middle, Maiden Surname) LENA Hyatt		19. Informant's Name/Relationship (Type, Print) MILDRED Berman / WIFE	
19a. Informant's Name/Relationship (Type, Print) MILDRED Berman / WIFE		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3119 NORTHBROOK ROAD - BALTIMORE, MD 21208			
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) BETH JACOB CEMETERY		20c. Location - City or Town, State 2/9/2004 FINKSBURG, MD	
21. Signature of Funeral Service Licensee 		22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Internal hemorrhage Due to (or as a consequence of): b. Ruptured Diverticulum Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last c. Due to (or as a consequence of): d. Due to (or as a consequence of):		23b. If FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <input type="checkbox"/> Unknown	
23d. Date of delivery Month Day Year		23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown			
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M	
28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred			
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier 		29c. License number RES-000	
29d. Date signed (Month, Day, Year) February 6, 2004		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) JENNIFER J. ADAMS MD SINAI HOSPITAL OF BALTIMORE			
31. Date filed (Month, Day, Year) FEB 11 2004		32. Registrar's Signature 			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2004 03987

1- For
State
Registrar

AMEND ITEM 20a-c&22 PER FH G828 2/12/04

Certificate of Death

Reg. No.

Physician
/Medical
ExaminerFuneral
Director

1. Decedent's Name (First, Middle, Last)

LELIA BURTON

2. Date of Death
Month Day Year
February 4, 20043. Time of Death
3:32 PM

4a. Facility Name (If not institution, give street and number)

Continuum Care of Sykesville

4b. City, Town, or Location of Death

Sykesville

4c. County of Death

Carroll

5. Social Security Number

213-20-3828

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

77

Yrs.

If Under 1 Year

Months

If Under 24 Hrs.

Days

Hours

Min.

8. Date of Birth

May 20, 1926

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

MD

10b. County

Carroll

10c. City, Town or Location

Sykesville

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

7309 2nd Avenue

10f. Zip Code

21784

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

1 ☒ Yes 2 ☐ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: white

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

10

College (1-4 or 5+)

0

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

custodial work

16b. Kind of Business/Industry

school system

17. Father's Name (First, Middle, Last)

John Grover

18. Mother's Name (First, Middle, Maiden Surname)

Lelia Eichelberger

19a. Informant's Name/Relationship (Type, Print)

Alice Burton/sister

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

11345 Pulaski Hgwy White March, MD 21162

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

MORELAND CEMETERY

Date

2/13/04

20c. Location - City or Town, State

BALTIMORE, MD.

21. Signatures of Funeral Service Licensee

Ronald S. Wade, Director

22. Name and Address of Facility

EVANS FUNERAL CHAPEL
State Anatomy Board 635 W. Baltimore Street
Baltimore, MD 21201-8800 HARFORD RD. PARKVILLE, MD.

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. ACUTE RESPIRATORY FAILURE

Due to (or as a consequence of):

b. ACUTE MYOCARDIAL INFARCTION

Due to (or as a consequence of):

c. ATHEROSCLEROTIC CARDIOVASCULAR DISEASE

Due to (or as a consequence of):

d.

Approximate Interval Between Onset and Death

= 2 min

= 5 min

= 2 days

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☐ No9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death4 ☐ Pregnant at time of death9 ☐ Unknown3 ☐ Ectopic pregnancy5 ☐ Other (Specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DDA

Other:

4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation2 ☐ Accident3 ☐ Suicide4 ☐ Homicide6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Ronald S. Wade, Director

29c. License number

D 40390

29d. Date signed (Month, Day, Year)

February 5, 2004

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

23 CROSSROADS DR. #325, OWINGS MILLS, MD 21115

31. Date filed (Month, Day, Year)

FEB 11 2004

32. Registrar's Signature

Ronald S. Wade

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural," or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2004 03988

1- For
State
Registrar

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Betty Lou Bell				2. Date of Death Month Day Year February 3, 2004				3. Time of Death 3:30 AM M		
	4a. Facility Name (If not institution, give street and number) Carroll County Hospital Center				4b. City, Town, or Location of Death Westminster				4c. County of Death Carroll		
Funeral Director	5. Social Security Number 213-34-5111		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 67 Yrs.		8. Date of Birth (Month, Day, Year) Dec 23, 1936		9. Birthplace (State or Foreign Country) West Virginia		
	Usual Residence of Decedent										
To Be Completed by Funeral Director	10a. State MD		10b. County Carroll		10c. City, Town or Location Hampstead				10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
	10e. Street and Number 3825 Shiloh Avenue #2				10f. Zip Code 21074		10g. Citizen of What Country? USA				
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: white			
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 6 College (1-4or 5+) 0				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) nurses aide			16b. Kind of Business/Industry hospitals			
	17. Father's Name (First, Middle, Last) William Liedy				18. Mother's Name (First, Middle, Maiden Surname) Versie Lewis						
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) Darlene Peterson/daughter				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4306 E. Main Street Lineboro, MD 21102						
	20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input checked="" type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Date		20c. Location - City or Town, State				
	21. Signature of Funeral Service Licensee Ronald S. Wade, Director				22. Name and Address of Facility State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201						
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) COPD a. Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of):				Approximate Interval Between Onset and Death years						
	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 9 <input type="checkbox"/> Unknown				23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) 9 <input type="checkbox"/> Unknown				23d. Date of delivery Month Day Year		
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input checked="" type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown			
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No							
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)							
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined				28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred	
28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)							
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.											
29b. Signature and title of certifier Herbert P. Henderson				29c. License number 000519241		29d. Date signed (Month, Day, Year) February 3, 2004					
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Herbert P. Henderson 5 MD 2973 Manchester Rd Manchester MD 21102											
31. Date filed (Month, Day, Year) FEB 11 2004				32. Registrar's Signature [Signature]							

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2004 03989

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

NELL LOUISE BARRON

2. Date of Death

01 13 2004

3. Time of Death

7 PM

4a. Facility Name (If not institution, give street and number)

THE WOODLANDS ASSISTED LIVING

4b. City, Town, or Location of Death

BALTIMORE

4c. County of Death

BALTIMORE

Funeral
Director

5. Social Security Number

258-01-5170

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

88 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Aug 19, 1915

9. Birthplace (State or Foreign Country)

Georgia

Usual Residence of Decedent

10a. State

MD

10b. County

Baltimore

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

1320 Windlass Drive

10f. Zip Code

21220

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: white

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

8

College (1-4 or 5+)

0

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

self employed

16b. Kind of Business/Industry

driving school

17. Father's Name (First, Middle, Last)

unk

18. Mother's Name (First, Middle, Maiden Surname)

unk

19a. Informant's Name/Relationship (Type, Print)

Rodney Renner/son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

228 South Street Box 261 Oxford, MD 21654

20a. Method of Disposition

1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☒ Other (Specify) in state

20b. Place of Disposition (Name of cemetery, crematory or other place)

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

Ronald S. Wade, Director

22. Name and Address of Facility

State Anatomy Board 655 W. Baltimore Street

Baltimore, MD 21201

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Poorly Differentiated Large Cell Lymphoma unknown

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

a. Due to (or as a consequence of):
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Advanced Dementia
Chronic Malnutrition

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Assisted

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

Living

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

MD

29c. License number

D-38754

29d. Date signed (Month, Day, Year)

01-22-2004

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

MALIKA WABERN. 709. EASTERN BLVD - MD - 21221

31. Date filed (Month, Day, Year)

FEB 11 2004

32. Registrar's Signature

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23e-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2004 03990

1- For State Registrar

Physician /Medical Examiner

Funeral Director

1. Decedent's Name (First, Middle, Last) Janette Carter		2. Date of Death Month February Day 6 Year 2004		3. Time of Death 20:00 M	
4a. Facility Name (If not institution, give street and number) JOHNS HOPKINS HOSPITAL		4b. City, Town, or Location of Death BALTIMORE CITY		4c. County of Death NIA	
5. Social Security Number 284-36-9525	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 64 Yrs.	8. Date of Birth (Month, Day, Year) SEPT. 21, 1939	9. Birthplace (State or Foreign Country) OHIO	

10a. State OHIO		10b. County STEUDBENVILLE		10c. City, Town or Location STEUDBENVILLE		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
10e. Street and Number 312 GARFIELD AVENUE		10f. Zip Code 43952		10g. Citizen of What Country? USA			
11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: BLACK	

15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <input type="checkbox"/> College (1-4 or 5+) <input checked="" type="checkbox"/> 2 YRS		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) MEDICAL ASSISTANT/CLERK		16b. Kind of Business/Industry PHYSICIANS OFFICE	
--	--	---	--	--	--

17. Father's Name (First, Middle, Last) CHARLES HERMAN CARTER		18. Mother's Name (First, Middle, Maiden Surname) EVA L. SMITH	
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19a. Informant's Name/Relationship (Type, Print) JANE M. HYMAN (SISTER)		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 312 GARFIELD AVE. STEUBENVILLE, OHIO 43952	
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20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) UNION CEMETERY		20c. Location: City or Town, State OHIO	
21. Signature of Funeral Service Licensee 		22. Name and Address of Facility JOSEPH H. BROWN JR. FUNERAL HOME 2140 N. FULTON AVE. BALD. MD. 21217			

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. acute respiratory distress syndrome		Approximate Interval Between Onset and Death 3 weeks	
Due to (or as a consequence of): b. sepsis		3 weeks	
Due to (or as a consequence of): c. methicillin-resistant staphylococcus aureus		3 weeks	
Due to (or as a consequence of): d.			

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Other (specify)		23d. Date of delivery Month Day Year	
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Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown	
		24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	

25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M	
		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		28d. Describe how injury occurred	
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)	

29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.	
--	--

29b. Signature and title of certifier 		29c. License number RES-000		29d. Date signed (Month, Day, Year) February 6, 2004	
---	--	---------------------------------------	--	--	--

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CHRISTINA VASSILEVA 600 North Wolfe Street Baltimore, MD 21287-9106	
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31. Date filed (Month, Day, Year) FEB 11 2004		32. Registrar's Signature 	
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Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

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To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2004 03991

Certificate of Death

Reg. No.

1- For
State
Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Cynthia Collins		2. Date of Death Month February Day 5 Year 2004		3. Time of Death 4:39 PM
	4a. Facility Name (If not institution, give street and number) Johns Hopkins Hospital		4b. City, Town, or Location of Death Baltimore City		4c. County of Death N/A
Funeral Director	5. Social Security Number 218-80-1754	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 43 Yrs.	8. Date of Birth (Month, Day, Year) Oct. 07, 1960	9. Birthplace (State or Foreign Country) MARYLAND
	Usual Residence of Decedent				
To Be Completed by Funeral Director	10a. State MARYLAND	10b. County N/A	10c. City, Town or Location BALTIMORE CITY		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
	10e. Street and Number 241 S. HERRING COURT		10f. Zip Code 21231		10g. Citizen of What Country? USA
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:
	14. Race - American Indian, Black, White, etc. BLACK		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12TH GRADE College (1-4or 5+) UNEMPLOYED		
	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) N/A		18b. Kind of Business/Industry N/A		
To Be Completed by Physician/Medical Examiner	17. Father's Name (First, Middle, Last) (UNKNOWN)		18. Mother's Name (First, Middle, Maiden Surname) DOROTHY JONES		
	19a. Informant's Name/Relationship (Type, Print) BRIAN COLLINS (HUSBAND)		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 241 S. HERRING CT. BALTO. MD 21231		
	20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) METRO CREMATORY		20c. Location - City or Town, State BALTIMORE, MARYLAND
	21. Signature of Funeral Service Licensee [Signature]		22. Name and Address of Facility BROWN JR. FUNERAL HOME 5940 N. FULTON AVE., BALTO., MD 21217		
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Hypoxia b. Pneumonia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last c. d.		Approximate Interval Between Onset and Death Two Months Three Months		
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Other (Specify)		23d. Date of delivery Month Day Year	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Type I Renal Tubular Acidosis Recurrent Clostridium Difficile Diarrhea					
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	28d. Describe how injury occurred
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier [Signature] MD		29c. License number RES-000	29d. Date signed (Month, Day, Year) February 6, 2004
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Susan Cheng 600 North Wolfe Street Baltimore, MD 21207					
31. Date filed (Month, Day, Year) FEB 11 2004		32. Registrar's Signature [Signature]			

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

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Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Unpend Item #23a, 27, 28a-f, Per ME, 0828, 2/13/04
 State of Maryland Department of Health and Mental Hygiene
 Certificate of Death
 Reg. No. 2004 03992

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) TOMORE NICOLE COLEMAN		2. Date of Death Month Day Year February 4, 2004		3. Time of Death 0613 P.M.
	4a. Facility Name (If not institution, give street and number) Johns Hopkins Hospital		4b. City, Town, or Location of Death Baltimore		4c. County of Death N/A
Funeral Director	5. Social Security Number 218-84-5525	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 32 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.
	8. Date of Birth (Month, Day, Year) DEC. 28, 1971		9. Birthplace (State or Foreign Country) MARYLAND		
To Be Completed by Funeral Director	10a. State MARYLAND		10b. County N/A		10c. City, Town or Location BALTIMORE CITY
	10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No				
	10e. Street and Number 1632 BRUCE CT.		10f. Zip Code 21217		10g. Citizen of What Country? U.S.A.
	11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:
To Be Completed by Physician/Medical Examiner	15. Decedent's Education (Specify only highest grade completed) 11th GRADE		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) COOK		16b. Kind of Business/Industry RESTAURANT
	17. Father's Name (First, Middle, Last) JOHNNIE SKINNER		18. Mother's Name (First, Middle, Maiden Surname) VALERIE COLEMAN		
	19a. Informant's Name/Relationship (Type, Print) VALERIE MACK (MOTHER)		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1632 BRUCE CT., BALTIMORE, MD 21217		
	20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) METRO CREMATORY		20c. Location - City or Town, State 22-11-04 BALTIMORE, MARYLAND
Physician /Medical Examiner	21. Signature of Funeral Service Licensee N. Williams		22. Name and Address of Facility JOSEPH F. BROWN JR. FUNERAL HOME 2140 N. FULTON AVE., BALTO. MD. 21217		
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.				
	Immediate Cause (Final disease or condition resulting in death) a. Narcotic Intoxication Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of):				
	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last				
Division of Vital Records, P.O. Box 68760,	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Unknown		23d. Date of delivery Month Day Year
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				
	23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown				
	24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		
	27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year) 2/4/04		28b. Time of Injury unknown M
	28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred unknown		
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) House		28f. Location (Street and Number or Rural Route Number, City or Town, State) 220 S. East Ave., Baltimore, MD		
State Registrar	29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				
	29b. Signature and title of certifier [Signature]		29c. License number OCME		29d. Date signed (Month, Day, Year) February 5, 2004
	30. Name and address of person who furnished cause of death (Item 23a) (Type, Print) J. LARON LOCKE, MD 111 Penn Street, Baltimore, Maryland 21201				
	31. Date filed (Month, Day, Year) FEB 11 2004		32. Registrar's Signature [Signature]		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

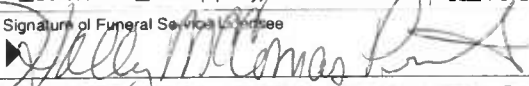
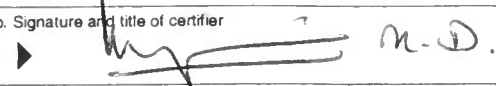

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2004 03993

1- For
State
Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Ella Mae Cushman				2. Date of Death Month Day Year February 9, 2004		3. Time of Death 1:10 AM	
	4a. Facility Name (If not institution, give street and number) 307 Tall Pines Ct.				4b. City, Town, or Location of Death 21009		4c. County of Death Harford	
Funeral Director	5. Social Security Number 220-20-1635		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 76 Yrs.		8. Date of Birth (Month, Day, Year) Dec. 15, 1927	
	9. Birthplace (State or Foreign Country) Maryland		10a. State Maryland		10b. County Harford		10c. City, Town or Location Abingdon	
To Be Completed by Funeral Director	10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		10e. Street and Number 307 Tall Pines Court		10f. Zip Code 21009		10g. Citizen of What Country? USA	
	11. Marital Status 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 2 College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Secretary		16b. Kind of Business/Industry U.S. Government			
	17. Father's Name (First, Middle, Last) Joseph (nmn) Cushman				18. Mother's Name (First, Middle, Maiden Surname) Bertha (nmn) Winkler			
	19a. Informant's Name/Relationship (Type, Print) Personal Charles E. Polesne / Rep.				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) P.O. Box 143, Whitmarsh, MD 21162-0143			
	20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Hilltop Service Corp. 2-13-04		20c. Location - City or Town, State Towson, Maryland			
	21. Signature of Funeral Service Licensee 		22. Name and Address of Facility McComas Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, Maryland 21009					
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Metastatic Lung Cancer							
	23b. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
	23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) 9 <input type="checkbox"/> Unknown							
23d. Date of delivery Month Day Year								
23e. Did tobacco use contribute to the cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown								
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No								
24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No								
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No								
26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)								
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined								
28a. Date of Injury (Month, Day Year) 28b. Time of Injury M 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 28d. Describe how injury occurred 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)								
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
29b. Signature and title of certifier  M.D.								
29c. License number D45390								
29d. Date signed (Month, Day, Year) FEBRUARY 9th, 2004								
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MYO MIN(M.D.) 602 SOUTH ATWOOD ROAD, #200, BELAIR, MD 21014								
31. Date filed (Month, Day, Year) FEB 11 2004								
32. Registrar's Signature 								

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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

1- For
State
Registrar

2004 03994

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Raymond George Crouch				2. Date of Death Month Day Year February 8, 2004		3. Time of Death 0811 A M	
	4a. Facility Name (If not institution, give street and number) St Agnes Healthcare				4b. City, Town, or Location of Death Baltimore		4c. County of Death N/A	
Funeral Director	5. Social Security Number 216-28-1429		6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		7. Age (In yrs. last birthday) 71 Yrs.		8. Date of Birth (Month, Day, Year) April 29, 1932	
							9. Birthplace (State or Foreign Country) Maryland	
To Be Completed by Funeral Director	Usual Residence of Decedent							
	10a. State Maryland		10b. County N/A		10c. City, Town or Location Baltimore			10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
	10e. Street and Number 3531 Wilkens Ave.				10f. Zip Code 21229		10g. Citizen of What Country? U. S. A.	
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates: 1947-1949		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 10 College (1-4or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Order Selector		16b. Kind of Business/Industry Food Distribution	
	17. Father's Name (First, Middle, Last) Raymond Crouch				18. Mother's Name (First, Middle, Maiden Surname) Emma Walters			
	19a. Informant's Name/Relationship (Type, Print) Dolores Crouch, wife				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3531 Wilkens Ave. Baltimore, MD. 21229-5106			
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Loudon Park Cemetery		Date 02-11-04		20c. Location - City or Town, State Baltimore, MD	
	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility Ambrose Funeral Home, Inc. 1328 Sulphur Spring Rd. Arbutus, MD. 21227			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. ASCVD Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last							
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 9 <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 4 <input type="checkbox"/> Pregnant at time of death 9 <input type="checkbox"/> Unknown		3 <input type="checkbox"/> Ectopic pregnancy 5 <input type="checkbox"/> Other (specify)		23d. Date of delivery Month Day Year		
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Diabetes						23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown		
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No						
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)						
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28d. Describe how injury occurred				
28f. Location (Street and Number or Rural Route Number, City or Town, State)								
29a. Certifier (Check only one) 2 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.								
29b. Signature and title of certifier MD				29c. License number D0053312		29d. Date signed (Month, Day, Year) February 8, 2004		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Michelle Hengstler, 900 Caton Avenue, Baltimore, MD 21229								
31. Date filed (Month, Day, Year) FEB 11 2004		32. Registrar's Signature 						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2004 03995

1- for
State
Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) FRANKIE CHAVIS				2. Date of Death Month Day Year January 28 2004		3. Time of Death 3:20 AM	
	4a. Facility Name (If not institution, give street and number) BOH SECOURS HOSPITAL				4b. City, Town, or Location of Death BALTIMORE		4c. County of Death Baltimore	
Funeral Director	5. Social Security Number 242-15-5325		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (in yrs. last birthday) 37 Yrs.		8. Date of Birth (Month, Day, Year) June 22, 1966	
	9. Birthplace (State or Foreign Country) North Carolina		10a. State Maryland		10b. County N/A		10c. City, Town or Location Baltimore	
To Be Completed by Funeral Director	10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No				10e. Street and Number 1162 Washington Blvd.		10f. Zip Code 21230	
	10g. Citizen of What Country? U.S.A.				11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:	
To Be Completed by Physician/Medical Examiner	13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: Native American		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 8 College (1-4or 5+) College (1-4or 5+)	
	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Painter				16b. Kind of Business/Industry Painting			
To Be Completed by Physician/Medical Examiner	17. Father's Name (First, Middle, Last) Jessie Chavis				18. Mother's Name (First, Middle, Maiden Surname) Annie Chavis			
	19a. Informant's Name/Relationship (Type, Print) Joey Jacobs -				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 117 Harley Rd., Lumberton, NC 28358			
To Be Completed by Physician/Medical Examiner	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Chavis Family Cemetery		20c. Location - City or Town, State Rowland, NC	
	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility Boles Funeral Home 312 W. Main Street Rowland, NC			
To Be Completed by Physician/Medical Examiner	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. STAPHYLOCOCCAL SEPTICEMIA				Approximate Interval Between Onset and Death			
	23b. Part 2. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last				23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <input type="checkbox"/> Unknown			
To Be Completed by Physician/Medical Examiner	23d. Date of delivery Month Day Year				23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown			
	24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No			
To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide				28a. Date of Injury (Month, Day, Year) M			
To Be Completed by Physician/Medical Examiner	28b. Time of Injury M				28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
	28d. Describe how injury occurred				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			
To Be Completed by Physician/Medical Examiner	28f. Location (Street and Number or Rural Route Number, City or Town, State)				29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.			
	29b. Signature and title of certifier Rosita R. Cruz				29c. License number D00303 SS			
To Be Completed by Physician/Medical Examiner	29d. Date signed (Month, Day, Year) January 28, 2004				30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ROSITA R. CRUZ M.D. BOH SECOURS HOSPITAL			
	31. Date filed (Month, Day, Year) FEB 11 2004				32. Registrar's Signature 			

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene
 1- Amend Item #5 per In 6830 4/28/04 tas
 AMEND ITEM #30 PER DVR G828 2/11/04 Certificate of Death
 Reg. No. 2004 03996

Physician
/Medical
Examiner

Funeral
Director

Physician
/Medical
Examiner

Medical Certification; To Be Completed by Physician/Medical Examiner

State
Registrar

1. Decedent's Name (First, Middle, Last) Evelyn B. Cate		2. Date of Death Month Day Year January 17, 2004		3. Time of Death 5:00 PM	
4a. Facility Name (If not institution, give street and number) 2509 Cecil Drive		4b. City, Town, or Location of Death Chester		4c. County of Death Queen Anne's	
5. Social Security Number 066-22-6463	6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (in yrs. last birthday) 91 Yrs.	8. Date of Birth (Month, Day, Year) Nov 24, 1912	9. Birthplace (State or Foreign Country) unk	
Usual Residence of Decedent					
10a. State MD	10b. County Queen Anne's	10c. City, Town or Location Chester		10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
10e. Street and Number 2509 Cecil Drive		10f. Zip Code 21619		10g. Citizen of What Country? USA	
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:	
14. Race - American Indian, Black, White, etc. Specify: white		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) unk College (1-4 or 5+) unk			
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) housewife		16b. Kind of Business/Industry own home			
17. Father's Name (First, Middle, Last) Frank Lander Boyd			18. Mother's Name (First, Middle, Maiden Surname) Louies Mitchel		
19a. Informant's Name/Relationship (Type, Print) Michael Cate/son			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2509 Cecil Drive Chester, MD 21619		
20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input checked="" type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Date		20c. Location - City or Town, State	
21. Signature of Funeral Service Licensee Ronald S. Wade, Director		22. Name and Address of Facility State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. acute coronary event Due to (or as a consequence of): b. arteriosclerotic cardiovascular disease Due to (or as a consequence of): c. Due to (or as a consequence of): d.					
Approximate Interval Between Onset and Death minutes years					
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 9 <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 4 <input type="checkbox"/> Pregnant at time of death 9 <input type="checkbox"/> Unknown		23d. Date of delivery Month Day Year	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. breast cancer COPD					
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
27. Manner of Death 1 <input type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M	
28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		28d. Describe how injury occurred			
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.					
29b. Signature and title of certifier H. B. S. M.D.		29c. License number D-5750		29d. Date signed (Month, Day, Year) 2-4-04	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ROBERT B. SANCHEZ 508 IDLEWILD AVENUE EASTON, MD. 21601					
31. Date filed (Month, Day, Year) FEB 11 2004		32. Registrar's Signature [Signature]			

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar AMEND ITEM #30 PER DVR G828 2/11/04 Certificate of Death

Reg. No.

2004 03997

Physician /Medical Examiner
Funeral Director

1. Decedent's Name (First, Middle, Last) Edna Virginia Cormack				2. Date of Death Month: January Day: 22, Year: 2004		3. Time of Death 10:15 AM	
4a. Facility Name (If not institution, give street and number) Ma Maison Asst Living				4b. City, Town, or Location of Death Perry Hall		4c. County of Death Baltimore	
5. Social Security Number 218-09-9224		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 86 Yrs.	If Under 1 Year Months: Days: Hours: Min.	8. Date of Birth (Month, Day, Year) Sept 10, 1917	9. Birthplace (State or Foreign Country) Maryland	
Usual Residence of Decedent							
10a. State MD		10b. County Baltimore		10c. City, Town or Location Perry Hall		10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
10e. Street and Number 9404 Belair Road				10f. Zip Code 21236		10g. Citizen of What Country? USA	
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: white	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12): 12 College (1-4 or 5+): 0				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) homemaker		16b. Kind of Business/Industry own home	
17. Father's Name (First, Middle, Last) Edward Benson Smith				18. Mother's Name (First, Middle, Maiden Sumame) Annie Dawson			
19a. Informant's Name/Relationship (Type, Print) Susan Jane Krause/daughter				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 13603 Red Squirrel Way Herndon, VA 20171			
20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input checked="" type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place)		Date		20c. Location - City or Town, State	
21. Signature of Funeral Service Licensee Ronald S. Wade, Director				22. Name and Address of Facility State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201			

To Be Completed by Funeral Director

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) abdominal cancer				Approximate Interval Between Onset and Death			
a. Due to (or as a consequence of):							
b. Due to (or as a consequence of):							
c. Due to (or as a consequence of):							
d. Due to (or as a consequence of):							
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 9 <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 4 <input type="checkbox"/> Pregnant at time of death 9 <input type="checkbox"/> Unknown		3 <input type="checkbox"/> Ectopic pregnancy 5 <input type="checkbox"/> Other (specify)		23d. Date of delivery Month: Day: Year:	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown	
						24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
						24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA		26. Place of Death (Check only one) Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28d. Describe how injury occurred			
		28f. Location (Street and Number or Rural Route Number, City or Town, State)					
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier		29c. License number D37612		29d. Date signed (Month, Day, Year) 2-3-04	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MOHAMAD ALBRASH MA MAISON ASSISTED LIVING PERRY HALL, MD.							

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,
Baltimore, Maryland 21215-0036
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

State Registrar

31. Date filed (Month, Day, Year) FEB 11 2004		32. Registrar's Signature Richard S. Wade	
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ORIGINAL

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State of Maryland / Department of Health and Mental Hygiene

2004 03998

1- For State Registrar

Certificate of Death

Reg. No.

Physician / Medical Examiner	1. Decedent's Name (First, Middle, Last) Nellie Collins				2. Date of Death Month: February Day: 08 Year: 2004				3. Time of Death 6:43 P M	
	4a. Facility Name (If not institution, give street and number) Sinai Hospital of Baltimore				4b. City, Town, or Location of Death Baltimore City				4c. County of Death N/A	
Funeral Director	5. Social Security Number 216-42-3854		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 59 Yrs.		8. Date of Birth (Month, Day, Year) Jun 29, 1944		9. Birthplace (State or Foreign Country) Md.	
	Usual Residence of Decedent									
To Be Completed by Funeral Director	10a. State Maryland		10b. County N/A		10c. City, Town or Location Baltimore				10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
	10e. Street and Number 3001 Wylie Ave.				10f. Zip Code 21215		10g. Citizen of What Country? U.S.A.			
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: Black		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Folder			16b. Kind of Business/Industry Commercial Laundry		
	17. Father's Name (First, Middle, Last) Joseph Carter Sr.				18. Mother's Name (First, Middle, Maiden Surname) Norma L. Carter					
	19a. Informant's Name/Relationship (Type, Print) Fay Deal Daughter				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1774 Homestead Street Baltimore, Maryland 21218					
	20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Mt. Zion		Date 02/14/04		20c. Location - City or Town, State Landsdown, Maryland			
	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility Estep Brothers Funeral Home P.A. 1300 Eutaw Place Baltimore, MD 21217					
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Adenocarcinoma of Lungs Due to (or as a consequence of): b. _____ Due to (or as a consequence of): c. _____ Due to (or as a consequence of): d. _____ Approximate Interval Between Onset and Death 1 month									
	23b. IF FEMALE: Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 9 <input type="checkbox"/> Unknown									
23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) _____ 9 <input type="checkbox"/> Unknown										
23d. Date of delivery Month: _____ Day: _____ Year: _____										
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Diabetes mellitus, cerebrovascular accident										
23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown										
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No										
24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No										
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)								
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred		
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)								
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.										
29b. Signature and title of certifier MD				29c. License number RES 000		29d. Date signed (Month, Day, Year) 02/08/2004				
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) VISHNUPRIYA, KITTANE 2401 West Belvedere Avenue Baltimore Maryland 21215										
31. Date filed (Month, Day, Year) FEB 11 2004				32. Registrar's Signature 						

Patient known as Nellie Collins

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2004 03999

1- For State Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) SAMUEL CAIN				2. Date of Death Month 7 - Day 31 - Year 04		3. Time of Death 0644 AM	
	4a. Facility Name (If not institution, give street and number) UNION MEMORIAL HOSPITAL				4b. City, Town, or Location of Death BALTO. MD		4c. County of Death N/A	
Funeral Director	5. Social Security Number 225-20-7013		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (in yrs. last birthday) 80 Yrs.		8. Date of Birth Month 2 - Day 19 - Year 23	
	9. Birthplace (State or Foreign Country) VA.		10a. State MD		10b. County N/A		10c. City, Town, or Location BALTIMORE	
To Be Completed by Funeral Director	10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No				10e. Street and Number 441 CORRAINE AVE.		10f. Zip Code 21213	
	10g. Citizen of What Country? U.S.A.				11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:	
To Be Completed by Physician/Medical Examiner	13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: BLACK		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 7th College (1-4or 5+) N/A	
	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) MEAT PACKER				16b. Kind of Business Industry HUGE MEAT PLANT			
To Be Completed by Physician/Medical Examiner	17. Father's Name (First, Middle, Last) ROBERT CAIN				18. Mother's Name (First, Middle, Maiden Surname) MARGARET DEANE			
	19a. Informant's Name/Relationship (Type, Print) CATHERINE CAIN (Wife)				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 441 CORRAINE AVE. BALTO. MD. 21213			
To Be Completed by Physician/Medical Examiner	20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input checked="" type="checkbox"/> Other (Specify) ENTOMBMENT				20b. Place of Disposition (Name of cemetery, crematory or other place) GREENWOOD		20c. Date 2-6-04	
	20d. Location - City or Town, State BALTO. MD.				21. Signature of Funeral Service Licenses Cynthia P. Leumore			
To Be Completed by Physician/Medical Examiner	22. Name and Address of Facility JOSEPH C. BRADY, Jr. Home				23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Coronary Artery Disease Due to (or as a consequence of): Essential Hypertension			
	23b. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last				23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <input type="checkbox"/> Unknown			
To Be Completed by Physician/Medical Examiner	23d. Date of delivery Month Day Year				23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown			
	24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined				28a. Date of Injury (Month, Day Year) 28b. Time of Injury M 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No 28d. Describe how injury occurred			
To Be Completed by Physician/Medical Examiner	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)			
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				29b. Signature and title of certifier C. O'Name			
To Be Completed by Physician/Medical Examiner	29c. License number D30641				29d. Date signed (Month, Day, Year) February 5 2004			
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Ramesh Sahana 3400 Erdman Avenue Baltimore MD 21213				31. Date filed (Month, Day, Year) FEB 11 2004			
To Be Completed by Physician/Medical Examiner	32. Registrar's Signature [Signature]				33. Date of Death 7-31-04			
	34. Time of Death 0644				35. County of Death N/A			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend Item # 22, per FH, G829, 3/3/2004, gap, State of Maryland, Department of Health and Mental Hygiene
 1- For AMEND ITEM #15&20a-c PER FH G829 5/03/04 JH
 State Registrar AMEND ITEM #30 PER DVR G828 2/11/04 Certificate of Death

Reg. No.

2004 04000

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Curtis Culbreath				2. Date of Death Month Day Year February 4, 2004				3. Time of Death 7:00 PM	
	4a. Facility Name (If not institution, give street and number) Clinton Nursing & Rehab Center				4b. City, Town, or Location of Death Clinton				4c. County of Death Prince George's	
Funeral Director	5. Social Security Number 578-30-6709		6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		7. Age (In yrs. last birthday) 45 Yrs.		8. Date of Birth (Month, Day, Year) June 29, 1958		9. Birthplace (State or Foreign Country) Washington DC	
	Usual Residence of Decedent									
To Be Completed by Funeral Director	10a. State MD		10b. County Prince George's		10c. City, Town or Location Clinton				10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
	10e. Street and Number 9211 Stuart Lane				10f. Zip Code 20745		10g. Citizen of What Country? USA			
	11. Marital Status 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: black		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) unk 11th unk				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) caregiver			16b. Kind of Business/Industry private homes		
	17. Father's Name (First, Middle, Last) Hamp Culbreath				18. Mother's Name (First, Middle, Maiden Surname) Christine Butler					
	19a. Informant's Name/Relationship (Type, Print) Christine Franklin/mother				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5811 Burgundy Street Capital Heights, MD 20743					
	20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) RIVERDALE CREMATORY		Date 2/10/04		20c. Location - City or Town, State RIVERDALE, MD			
	21. Signature of Funeral Service Licensee Ronald S. Wade, Director				22. Name and Address of Facility Robert O. Freeman Funeral Services, Inc. State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201				1353 H Street Washington, D.C.	
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Acquired Immune Deficiency Syndrome Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last									
	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) 9 <input type="checkbox"/> Unknown				23d. Date of delivery Month Day Year			
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. CARDIOMYOPATHY										
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA		26. Place of Death (Check only one) Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown				
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred		
29a. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier B. Pishdad		29c. License number 51520		29d. Date signed (Month, Day, Year) 2-4-04				
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BAHRAM PISHDAD CLINTON NURSING & REHAB CENTER CLINTON, MD										
31. Date filed (Month, Day, Year) FEB 11 2004		32. Registrar's Signature Ronald S. Wade								

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28e-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
 To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner